STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675241	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Place	1307 Martin Luther King Dr Jefferson, TX 75657

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 of 24 residents (Resident #7, Resident #17, and Resident #50) reviewed for reasonable accommodations. The facility failed to ensure Resident #7, Resident #17, and Resident #50's call button was within reach while in bed. These failures could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity. Findings include: 1. Record review of Resident #7's face sheet, dated 4/19/24 revealed a [AGE] year old female admitted on [DATE] with diagnoses that included Pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus, which can make breathing difficult and painful), Dementia (a group of conditions that cause a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), and Hypertension (a chronic medical condition that occurs when the pressure in your blood vessels is consistently too high.) Record review of Resident #7's quarterly MDS assessment, dated 07/25/24, revealed Resident #7 had a BIMS of 99, which indicated she was unable to complete the BIMS test. Shows that resident #7 requires extensive assistance with ADLs. Record review of Resident #7's Comprehensive Care Plan revised 012/20/22 reflected Resident #7 was Resident had an ADL self-Care Performance Deficit regarding her disease process, immobility, and poor cognition. During an interview and observation on 9/16/24 at 9:55 a.m., it was observed that Resident #7's call button was laying on the floor. It was observed that Resident #7's bed was in the high position. Resident #7 said that her call button had been laying on the floor all night and all morning. She said that she could not reach the call light button. She said if she needed help, she would not be able to ask for help and she would have to wait until someone came into her room. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #17's face sheet, dated 1/4/24 revealed a [AGE] year old female admitted on [DATE] with diagnoses that included Systolic Heart Failure (occurs when the left ventricle of the heart is too weak to pump enough blood to the body), Hypertensive Herat Disease (a constellation of changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation), Old Myocardial Infarction (a previous heart attack that's detected by an electrocardiogram (ECG) as pathologic Q waves in the heart). Record review of Resident #17's annual MDS assessment, dated 07/24/24. The MDS indicated a BIMS score of 12 indicating Resident #17's cognition was moderately impaired. The MDS indicated Resident #17 required partial assistance from staff for activities of daily living. Record review of Resident #17's Comprehensive Care Plan revised 07/29/24 reflected Resident #17 required staff to, Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. During an interview and observation on 9/16/24 at 9:38 a.m., Resident #17's call button was observed far under her bed. She said she never pushes her call button because she can never reach it. She said that she would use it to call for help, but she would need someone to give it to her. She asked the surveyor to pick the call button off the floor for her. 3. Record review of Resident #50's face sheet, dated 2/22/23 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included Muscular Degeneration (a group of genetic diseases that cause progressive muscle weakness and breakdown), Hyperlipidemia (a condition where there are high levels of lipids, or fats, in the blood), Hypertension (a chronic medical condition that occurs when the pressure in your blood vessels is consistently too high.) Record review of Resident #50's quarterly MDS assessment, dated 08/14/24, revealed Resident #50 had a BIMS of 08, which indicated she had moderately impaired cognition. Shows that resident #50 requires extensive assistance with ADLs. Record review of Resident #50's Comprehensive Care Plan revised 03/10/23 reflected Resident #50 required staff to, Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. During an observation on 9/16/24 at 9:50 a.m., Resident #50's call button was laying on the floor behind a dresser. Call button was several feet away from the resident and behind furniture. Surveyor had to move the dresser away from the wall in order to get to the call button. During an interview on 9/18/24 at 1:32 p.m., with CNA L she said it was the responsibility of CNAs to ensure residents have call buttons within their reach. She said if a resident could not reach their call light or have the ability to get up and get their call light then they would have no way to communicate to staff if they needed help or assistance. She said this could place residents at risk of not getting the help they needed. During an interview on 9/18/24 at 3:15 p.m., with the DON she said that all staff are responsible for ensuring that residents call buttons were within reach. She said that if a resident that was dependent for care could not reach their call button they would not be able to ask for help. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/24 at 3:30 p.m., with the ADM he said that all staff are responsible to ensure that residents have a call button within reach when they are entering and leaving residents rooms. He said residents who needed help were placed at risk if they were unable to reach their call button. Record review of the facility's policy Answering the Call light revised September 2022 reflected . The purpose of this procedure is to ensure timely responses to the resident's requests and needs Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to ensure that that all alleged violations involving a drug diversion were reported after the allegation was made to other officials (including to the State Survey Agency) in accordance with State law through established procedures for 1 resident (Resident #25) of 4 resident reviewed for drug diversion in that: The facility was made aware of a possible drug diversion on 07/12/2024. LVN M reported to the ADM receiving a bottle of hydromorphone from Hospice Nurse N that was tampered with upon receipt of the medication. This failure could result in allegations or instances of resident drug diversion not being reported or investigated by the state survey agency. Findings include: Record review of an undated face sheet indicated Resident #25 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), COPD (A group of lung diseases that block airflow and make it difficult to breathe), and diabetes mellitus. Record review of a quarterly MDS dated [DATE] indicated Resident # 25 had a BIMS of 06, which indicated cognitive impairment. He required extensive to dependent assistance with ADLs such as transfer, bathing, and toileting. Resident #25 had no pain, and no pain medication was administered. During an interview on 09/17/2024 at 10:00 a.m., Resident #25 was able to answer limited questions. He stated his name and date of birth. He stated he had no pain and was doing fine. During an interview on 09/17/2024 at 10:30 a.m., Resident #25's family stated he was informed of the mishandling of his father's pain medication on 08/23/2024 by a nurse that worked for the state. He stated he was not notified prior to that day of the mishandling of his father's pain medication. He stated he was not greatly concerned about the information because his father rarely complained of pain. During an interview with HHS Nurse O on 09/18/2024 at 10:20 a.m., she stated she worked a reported complaint on 08/23/2024 regarding Hospice Nurse N. She stated the complaint alleged Hospice Nurse N ordered a bottle of hydromorphone for Resident #25 on 07/06/2024 and delivered it to the facility on [DATE]. Upon receipt of the hydromorphone, LVN M noticed the medication was tampered with and reported the information to the ADM. The ADM notified the hospice company on 07/08/2024 of the incident. The hospice company sent RN P out to retrieve the medication to have it tested . HHS Nurse O stated she advised the ADM that he should have reported the incident as a drug diversion because it was the facility's resident whose medication was diverted. She stated he said he had not looked at the situation in that manner, but he would report the incident immediately. HHS Nurse O stated it had not harmed the resident because he had 3 unused sealed bottles of hydromorphone on the medication cart if he needed them for pain control. (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 09/18/2024 at 11:45 a.m., Hospice Nurse P stated the medication was picked up from the facility on 07/10/2024 by herself. She stated instantly she knew the medication had been tampered with. She stated the seal was broken and the liquid was clear and thin like water. She stated hydromorphone was generally thicker in nature. She stated it was not best practice to keep narcotics overnight at their homes. She stated the nurse should have delivered the medication the same day she received it. She stated the nurse should have never reordered the medication if Resident #25 was not low on the medication. She stated all the details lead to a referral of Hospice Nurse N's license. During an interview on 09/18/2024 at 12:20 p.m., the ADM stated he was made aware of the medication tampering on 07/07/2024 by LVN M. He stated the next day when he came into work, he called the hospice company and informed them of the situation. He stated a few days later Hospice RN P came and retrieved the medication. He stated he never thought of the situation of a drug diversion that he would have needed to report because it was not his nurse that diverted the drug. He stated he thought the hospice company would call in the diversion on their end. He stated he had not investigated the situation any further because it was cut and dry to him. He stated he reported the incident to HHS and called the local police after HHS Nurse O suggested to him he needed to. He stated had he thought once the Hospice company had investigated it the situation was resolved. Record review of an undated policy entitled Reporting revealed, nursing facilities must report all allegations of drug theft (diversion) within 24 hours to the State survey and certification agency (State survey agency), and to other officials in accordance with State law.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for 3 of 9 residents reviewed for new admissions (Resident #2, Resident #36, and Resident #190). The facility failed to complete a baseline care plan for Resident #36 within 48 hours of admission. The facility failed to provide Resident #2 and Resident #190's RP, a copy of the summary of the baseline care plan. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of Resident #36's face sheet dated 09/16/24 indicated Resident #36 was an 85-years-old, male admitted to the facility on [DATE] and 09/04/24 with diagnoses including fracture of upper end of left femur (is a break in the uppermost part of thighbone, next to the hip joint), Extended Spectrum Beta Lactamase (ESBL) resistance (is an enzyme that is produced by bacteria to become resistant to extended-spectrum penicillin, cephalosporins, and monobactams except for cephamycins and carbapenems), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and repeated falls. Resident #36's responsible party was a family member. Record review of Resident #36's admission MDS assessment dated [DATE] indicated Resident #36's admission entry date was 09/04/24. Resident #36 was understood and understood others. Resident #36 had a BIMS score of 08 which indicated moderately cognitive impairment. Resident #36's admission performance requirement was substantial assistance for toilet hygiene, shower/bathe self, and lower body dressing, partial assistance for upper body dressing and personal hygiene, and supervision for oral hygiene. Resident #36 was occasionally incontinent of urine and always continent for bowel. Resident #36 had a multidrug-resistant organism (MDRO). Resident #36 had falls in the last month, last 2-6 months, and fracture related to a fall in the 6 months prior to admission. Resident #36 was on a mechanically altered diet. Resident #36 was at risk of developing pressure ulcers/injuries, had 2 venous and arterial ulcers, skin tear(s), and surgical wounds. Resident #36 received antibiotics, opioid, and insulin during the last 7 days. Resident #36 had intravenous access and medication. On 09/17/24 at 9:30 a.m., the DON provided a baseline care plan for Resident #36. The baseline care plan was dated 07/05/24 which was the previous admitted . The facility did not provide a baseline care plan for admitted [DATE]. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #2's face sheet dated 09/16/24 indicated Resident #2 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including sepsis (is a serious condition in which the body responds improperly to an infection) due to enterococcus (gram-positive, sphere-shaped (coccal) bacteria), megaloureter (an enlarged ureter), acquired absence of left leg above knee, obstructive (occurs when urine cannot drain through the urinary tract) and reflux (is kidney scarring caused by urine flowing backward from the bladder into a ureter and toward a kidney) uropathy, and atherosclerotic heart disease (is a common condition that develops when a sticky substance called plaque builds up inside your arteries). Resident #2 responsible party was a family member. Record review of Resident #2's admission MDS assessment dated [DATE] indicated Resident #2 was understood and usually understood others. Resident #2's BIMS score was 11 which indicated moderately cognitive impairment. Resident #2 admission performance requirement was substantial assistance for lower body dressing, partial assistance for personal hygiene, upper body dressing, shower/bathe self and toilet hygiene, and supervision for oral hygiene. Record review of Resident #2's undated baseline care plan did not reflect a signature and date of resident and representative or signature of staff completing plan, title, and date. On 09/23/24 at 11:40 a.m., a call was placed to Resident #2's responsible party, no answer and message was left. 3. Record review of Resident #190's face sheet dated 09/16/24 indicated Resident #190 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease (is a common condition that develops when a sticky substance called plaque builds up inside your arteries), aneurysm of the ascending aorta (is a bulging, weakened area in the wall of a blood vessel resulting in an abnormal widening or ballooning greater than 50% of the vessel's normal diameter (width)), without rupture, presence of heart valve replacement, chronic obstructive pulmonary disease (is a common lung disease causing restricted airflow and breathing problems), encounter for attention to tracheostomy (is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), and Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Resident #190 responsible party and care conference person was a family member. Record review of Resident #190's admission MDS assessment dated [DATE] indicated Resident #190 was understood and understood others. Resident #190's BIMS score was 15 which indicated intact cognition. Resident #190's admission performance requirement was partial assistance for lower body dressing, shower/bathe self, and toilet hygiene, supervision assistance for upper body dressing, and set-up assistance for oral hygiene. Record review of Resident #190's undated baseline care plan did not reflect a signature and date of resident and representative or signature of staff completing plan, title, and date. The undated baseline care plan indicated Resident #190 was his own representative. During an interview on 09/18/2024 at 11:30 a.m., Resident #190's responsible party and care conference person said she did not receive a copy of Resident #190's baseline care plan. She said she would have liked to have received a copy of Resident #190's care plan. She said a copy of Resident #190's baseline care plan would have helped her know what was going on with her family member. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 1:11 p.m., LVN Q said baseline care plan were supposed to done within 24-48 hours of an admission. She said if the admitting nurse did not complete the baseline care plan, the next nurse should. She said the nurse who completed the baseline care plan was responsible for getting it signed by the resident or responsible party and providing a copy. She said baseline care plans were important to know the resident's care and needs. She said the resident or responsible party should have a copy, so they were also aware of the care being provided. She said not having a baseline care plan completed placed residents at risk for not getting the needs met. During an interview of 09/18/24 at 1:44 p.m., LVN R said she was the admit nurse for Resident #36 and Resident #190. She said the MDS coordinator, ADON, DON, and ADM were responsible for baseline care plans. She said she did not know the timeframe the baseline care plan had to be completed by. She said maybe it was completed during the admission care plan meeting. She said she did know the baseline care plan was supposed to be signed by the resident or responsible party and copy given. She said baseline care plans were important to make sure resident's care, needs, and wants were documented. She said baseline care plans were also important to ensure the resident's wishes were being honored. She said not having a baseline care plan placed residents at risk for their issues not being addressed. During an interview on 09/18/24 at 3:54 p.m., the DON said the ADON, DON, and MDS coordinator were responsible for baseline care plans. She said the baseline care plan should be started on admission and completed within 48 hours. She said the MDS coordinator, ADON, and DON were responsible for providing a copy to the resident and responsible party. She said the baseline care plan was supposed to be given to the resident or responsible party at the first care plan meeting. She said the baseline care plan was important because it gave the overall plan of care, established good communication between the facility and resident. She said the baseline care plan was also important to know the resident's needs and wants. She said not having a baseline care placed residents at risk for communication not being established and discharge planning not being communicated. She said Resident #36 was previously admitted then went to an assisted living facility. She said Resident #36 fell at the assisted living facility and was admitted to the facility again. She said Resident #36's new admission baseline care plan was missed. During an interview on 09/18/24 at 4:30 p.m., the ADM said baseline care plans were supposed to be completed within 48 hours of admission. He said the interdisciplinary team was responsible for completing the baseline care plans. He said baseline care plans were important to understand what the resident needed and how to take care of them. Record review of a facility's Care Plans-Baseline policy revised on 03/2022 indicated .a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission .the resident and/or representative are provided a written summary of the baseline care plan .provision of the summary to the resident and/or representative is documented in the medical record .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 2 of 26 residents reviewed for care plans.(Resident #30 and Resident #43). 1. The care plan for Resident #30 failed to address his Stage IV sacral pressure ulcer. 2. The care plan for Resident #43 failed to address new interventions and updates for fall prevention. Theses failures could place residents at risk for not receiving the necessary care or having important care needs identified. Findings include: 1. Record review of an undated face sheet indicated Resident #30 was a [AGE] year-old-male admitted to the facility on [DATE] with the diagnoses of spinal stenosis (condition in which the spinal canal narrows and puts pressure on the nerve root) and dementia (a group of conditions that can cause gradual decline in cognitive abilities), and diabetes mellitus. Record review of a quarterly MDS dated [DATE] indicated Resident #30 had a BIMS of 13, which suggested a mild cognitive impairment. He required extensive assistance with ADLs, such as transfer, toileting, and bed mobility. Resident #30 had (1) stage IV pressure ulcer noted with daily pressure ulcer care. Record review of wound management notes for Resident #30 indicated his Stage IV pressure ulcer resolved in May 2024 and reopened 08/05/2024. Record review of a care plan dated 05/08/2024 indicated Resident #30 had a resolved stage IV pressure ulcer to his sacrum on 05/08/2024. No care plan was noted for current pressure ulcer. During an interview on 09/17/2024 at 1:30 p.m., the MDS Coordinator stated she was responsible for care planning everything she claimed on the MDS. She stated Resident #30's pressure ulcer should have been implemented on a new care plan when it reopened on 08/05/2024 and it was her responsibility to ensure that happened. She stated it was an oversight that she had not created a new care plan for the pressure ulcer. During an interview on 09/18/2024 at 10:00 a.m., the DON stated the MDS nurse was responsible for care planning anything claimed on the MDS, but all nurse management helped to care plan acute things like infections and falls. She stated it was her responsibility to review the care plans quarterly and ensure they accurately depicted each resident individually. She stated Resident #30 should have had a care plan created when his pressure ulcer reopened. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/2024 at 11:30 a.m., the ADM stated it was the responsibility of the MDS Coordinator to care plan anything that was claimed on the MDS, and it was all nursing management's responsibility to do baseline and acute care plans. He stated individual care plans were important to accurately reflect each resident's needs. 49019 2. Record review of Resident #43's Admission Record indicated he was readmitted on [DATE] with diagnosis of protein-calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), dysphagia (a condition with difficulty in swallowing food or liquid), COPD (a chronic lung disease that makes breathing difficult and causes cough, mucus and wheezing), Parkinson's disease without dyskinesia (progressive disorder that affects the nervous system and parts of the body that controlled by the nerves), and Epilepsy (a brain disorder that causes recurring , unprovoked seizures). Record review of Resident #43's quarterly MDS dated [DATE] indicated that the resident was sometimes understood and sometimes was understood by others. Resident #43 had a BIMS score of 99 indicating he was not able to complete the interview. Record review of Resident #43's Care Plan revised on 5/9/2024, indicated Resident #43 was high risk for falls related to unaware of safety needs and diagnosis of dementia. Resident #43 had interventions initiated on 3/16/2022 for staff to anticipate and meet resident's needs, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, PT evaluate and treat as ordered or PRN, review information on past falls and attempt to determine cause of the falls and record possible root causes and alter remove potential causes if possible, educate resident/family/caregivers/IDT as to causes. The care plan indicated intervention for resident #43 needs a safe environment with: even floors, free from spills and or clutter, adequate glare-free light and a working reachable call light, the bed in low position at night and personal items within reach. Record review of Resident #43's care plan revised on 8/11/2023 indicated Resident #43 had following falls: 8/18/2023 fall with no injury. 8/21/2023 bruise to right foot after fall. 9/10/2023 attempted to stand alone, no injury. 11/6/2023 on the floor in the dining area. 11/12/2023 sitting on fall mat by bed. 12/17/2023 in dining area, stood up unassisted, no injury. 12/26/2023 fall with no injury, was on the floor from wheelchair. 1/27/2024 fall with bruised to right hand. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/28/2024 fall, ambulating without assistance, no injury. 4/13/2024 scooting on the floor. 5/24/2024 attempted to transfer unassisted. 5/29/2024 fall during an unassisted transfer, no injury. Record review of Resident #43's care plan for actual falls indicated on 11/11/2022 medications were reviewed and shoes were assessed, 11/16/2022 Non-slip mat placed under wheel chair cushion to prevent sliding out of wheelchair, hipsters provided, daughter refused for resident to have helmet says it will irritate him, 10/24/2022 continue fall mat, arm sleeves, therapy to screen and pick up if indicated education with resident representative and resident, 2/7/2023 continue with fall mat and place bed in lowest position, for no apparent acute injury, 10/24/2022 determine and address causative factors of the fall, 10/24/2022 neuro-checks per protocol if indicated, 3/15/2023 provide reminders to use call light for assistance, 10/24/2022 therapy consult as indicated, 5/25/2024 anticipate resident's needs and provide assistance as needed, 8/18/2023 continue with previous fall interventions, 11/12/2023 monitor for increased pain or changes in bruising to toes on left foot, notify MD as needed, 8/18/2023 place bed bolsters on bed, 2/5/2024 PT services in place, and 8/21/2023 x-ray ordered for right foot, negative for fractures. During an interview on 9/18/2024 at 1:00 PM, CNA D said she was not aware of any recent falls from Resident #43. She said she had not observed him falling. CNA D said Resident #43 was in a wheelchair and he has tried to get out of it before. She said Resident #43 requires 1 person transfer and requires cuing. CNA D said she would ask the nurse or the aide prior to her shift if any resident's had a fall on their shift. CNA D said she did not know which residents were a fall risk. CNA D said the resident would go to therapy if they had fallen. CNA D said if a resident had a fall, she would get the nurse to assess the resident for bruising, skin tears or injury. The CNA D said the aides are responsible for ensuring the care plan interventions for falls are in place and being implemented. CNA D said if a resident were having frequent falls, the resident would have a fall mat. The nurses place the fall mats for the residents. The CNA D said not having a fall mat in place or call light within reach could potentially prevent a fall or lessen the injury. The CNA D said they do not chart if the care plan was being implemented and the nurse was responsible for ensuring the interventions were implemented. During an interview on 9/18/2024 at 1:15 PM, CNA E said she had worked at the facility for approximately [AGE] years. She said she does care for any residents who have recently fallen. CNA E said she had been in-serviced on falls. CNA E said the facility had interventions to prevent falls included fall mats, call light within reach, signs on the resident's walls displaying call don't fall and making sure residents had proper footwear on. CNA E said the staff redirect residents while in the dining room to sit back down if they attempt to stand up. CNA E said it would be care planned if a resident was a high fall risk. She said the CNAs did have access to the care plan in the kiosk. CNA E said she would talk to the nurse and DON if she did not feel the interventions were effective. She said the DON and the ADON are responsible for ensuring the interventions are on the care plan. CNA E said a resident could call and hurt themselves if the interventions were not in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/2024 at 1:23 PM, LVN F said Resident # 43 had been found on the floor, but it was not necessary a fall. She said we classify everything as a fall. LVN F said Resident #43 would be observed on the floor and he was state I'm down here working. The LVN F said she thought it was care planned in Resident #43 chart. LVN F said she documents falls in the nurses note and said the nurse should complete a fall risk assessment and neurological checks if a resident was suspected of falling. LVN F said interventions for high-risk fall residents included checking on the residents more frequently, fall mat in place, and redirect a resident before they attempt to get up. LVN F said she would notify the DON if interventions were not working and would talk with family for suggestions. LVN F said Resident #43 had a bolster mattress, fall mat, frequent checks, and make sure call light was within reach. LVN F said the nurses do not document the frequent checks. LVN F said the MDS nurse was responsible for care plan and the LVN was responsible for making sure the interventions were implemented and followed. LVN F said the staff would not know what to do if the care plan was not updated. She said a resident could continue to fall or get injured. LVN F said everyone was responsible for implementing fall precautions. During an interview on 9/18/2024 at 1:41 PM, RN G said she does not know how to update the care plan and was not sure if the CNAs had access the care plan. RN G said she would assess the environment to see if a resident had a fall mat and said some residents have motion detectors that would set off the call light so a staff member would go check on them. RN G said she would talk with the DON about other interventions and the DON would update the care plan and discuss in the care plan meeting. RN G said she would complete a fall assessment after every fall along with skin assessment, pain assessment, and an incident report after every fall. RN G said the response would be noted in the incident report and she documents in the progress note. RN G said a resident could injury themselves or break something if they had a fall and said it was important to care plan because every day was different, and anything could change. During an interview on 9/18/2024 at 2:21 PM, MDS nurse H said the nurses would document resident responses to interventions in the nurse notes. MDS Nurse H said the DON would update the care plan with the actual fall and the IDT would put another intervention in place if the current interventions were not effective. MDS Nurse H said the nurse on the unit should complete a fall risk assessment after each fall and quarterly with other quarterly assessments. MDS Nurse H said the facility would not have everyone on board with the interventions if the interventions were not on the care plan and it could affect the continuity of care. During an interview on 9/18/2024 at 2:30 PM, MDS Nurse J said actual falls were documented and the facility would add interventions such as increased supervision, medication review, fall mats, low bed position and bolster mattress. MDS Nurse J said the DON was new and she adds the actual falls to the resident's care plan. During an interview on 9/18/2024 at 2:45 PM, the ADON said she had been in her role for approximately 5 months. The ADON said the care plans were discussed in the care plan meetings and they update the care plan. The ADON said the facility attempts to find the root cause and adjust the care plan at that point. She said if a resident continues to fall, the nurse will assess the residents needs and perform more frequent checks. The ADON said the facility does fall risk assessments as needed. The ADON said she would complete one after a fall. The ADON said everyone who was providing direct care was responsible for implementing care plan and the nurses providing direct care document if an intervention was effective. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/2024 at 2:53 PM, the DON said the MDS nurse, DON and charge nurses would put interventions in place for fall preventions. The DON said she was not sure if they have done an in-service since she had been there. The DON said their computer program triggers a fall risk assessment when the nurses complete an incident report. The DON said the facility should be updating the care plan but said sometimes the computer program would not allow additional falls. She said the updated the care plan on 8/1/2024 fall and updated the care plan on 8/12/2024 adding additional interventions. Previously saved care plan did not have a revision date on 8/12/2024 and the DON present a copy of revised care plan dated 8/12/2024. The DON said the nurses do follow-up on falls in the progress note. The DON pulled the last fall assessment which was dated 2/18/2024 and said the computer program was not triggering the fall assessment and said she had been back and forth with corporate on the computer system not triggering the fall assessments. The DON said in normal cases, the incident report would trigger a fall assessment. The DON said if the facility staff reads the care plan, it could prevent falls or injury. The DON said the nurses and CNAs are not going to read the care plans. During an interview on 9/18/2024 at 3:54 PM, the ADM said he expected the nurses to initiate the care plans. The ADM said the nurses are responsible for fall risk assessments to be completed and he was not sure how often the assessments should be completed. The ADM said the nurses should document the fall in the incident reporting section and the facility should be reviewing interventions and update as appropriate. The ADM said the facility had in-serviced the staff on fall prevention. The ADM said the administrative staff were responsible for ensuring the interventions were followed. The ADM said the care plans were discussed in the IDT meeting. The ADM said a resident could get injured if a fall intervention were not in place. Record review of a facility policy . Record review of a facility policy undated titled 'Comprehensive Care Planning revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The facility will establish, document, and implement the care and services to be provided for each resident to assist in attaining or maintaining his or her highest practical quality of life. Resident's preferences and goals may change throughout their stay, so facilities should have ongoing discussions with resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy dated March 2018 titled 'Falls and Fall Risk, Managing indicated .the staff will identify interventions related to the resident's specific risk and causes to try to prevent the resident from falling and to try to minimize complications from falling . Policy Interpretation and Implementation .Definition . According to MDS, a fall was defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g. a resident pushes another resident). An episode where a resident lost his or her balance and would have fallen, if not for another person or if he or she had not caught himself or herself, was considered a fall. A fall without injury was still a fall. Unless there was evidence suggesting otherwise, when a resident was found on the floor, a fall was considered to have occurred. Resident-Centered Approaches to managing falls and fall risk . 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk for with a history of falls. 2. If a systematic evaluation of a resident's fall risk identified several interventions, the staff may choice to prioritize interventions. 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing lighting .4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling .5. If falling recurs despite initial interventions, staff will implement additional or different interventions .6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling was reduced or stopped .7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. 8. Position-change alarms will not be used as the primary or sole intervention to prevent falls . Monitoring Subsequent Falls and Fall Risk . 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions .4. The staff and or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers based on the comprehensive assessment for 2 of 4 residents (Resident #36 and Resident #187) whose record were reviewed for skin integrity. The facility failed to ensure Resident #36 and Resident #187's pressure-relieving mattress (is designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) was on the correct settings. This failure could place residents at risk for developing and/or worsening of pressure ulcers Findings included: 1. Record review of Resident #36's face sheet dated 09/16/24 indicated Resident #36 was an [AGE] year-old, male admitted to the facility on [DATE] and 09/04/24 with diagnoses including fracture of upper end of left femur (is a break in the uppermost part of thighbone, next to the hip joint), Extended Spectrum Beta Lactamase (ESBL) resistance (is an enzyme that is produced by bacteria to become resistant to extended-spectrum penicillin, cephalosporins, and monobactams except for cephamycins and carbapenems), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and repeated falls. Record review of Resident #36's consolidated physician order dated 09/18/24 indicated pressure reducing mattress to bed, every shift for prevention. Start date 07/06/24. Record review of Resident #36's admission MDS assessment dated [DATE] indicated Resident #36 was understood and understood others. Resident #36 had a BIMS score of 08 which indicated moderately cognitive impairment. Resident #36's admission performance requirement was substantial assistance for toilet hygiene, shower/bathe self, and lower body dressing, partial assistance for upper body dressing and personal hygiene, and supervision for oral hygiene. Resident #36 was occasionally incontinent of urine and always continent for bowel. Resident #36 had a multidrug-resistant organism (MDRO). Resident #36 was at risk of developing pressure ulcers/injuries, had 2 venous and arterial ulcers, skin tear(s), and surgical wounds. Resident #36 had pressure reducing device for bed for skin and ulcer/injury treatments. Resident #36 was 203 pounds. Record review of Resident #36's care plan dated 09/05/24 indicated potential for impaired skin integrity as evidence by Braden scale for predicting pressure ulcer risk, high risk for pressure ulcer. Intervention included provide skin care per facility guideline and as needed. Record review of Resident #36's care plan dated 09/11/24 indicated Resident #36 had potential/actual impairment to skin integrity r/t surgical wound. Intervention included follow facility protocols for treatment of injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 09/16/24 at 9:11 a.m., Resident #36 was lying in bed on a pressure-relieving mattress. Resident #36's pressure-relieving mattress settings was 350 pounds. During an observation on 09/17/24 at 8:32 a.m., Resident #36 was lying in bed on a pressure-relieving mattress. Resident #36's pressure-relieving mattress settings was 350 pounds. 2. Record review of Resident #187's face sheet dated 09/16/24 indicated Resident #187 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including myocardial infarction (commonly known as a heart attack, is the irreversible necrosis of heart muscle secondary to prolonged ischemia), Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and pain in right knee. Record review of Resident #187's consolidated physician orders dated 09/18/24 indicated Pressure reducing mattress to bed, every shift. Start date 09/07/24. Record review of Resident #187's admission MDS assessment dated [DATE] indicated Resident #187 was understood and understood others. Resident #187 had a BIMS score of 12 which indicated moderately cognitive impairment. Resident #187's admission performance requirement was maximal assistance for lower body dressing, shower/bathe self, and toileting hygiene, moderate assistance for personal hygiene and upper body dressing, and supervision assistance for oral hygiene. Resident #187 was occasionally incontinent of urine and always continent for bowel. Resident #187 was at risk of developing pressure ulcer/injuries. Resident #187 had pressure reducing device for bed for skin and ulcer/injury treatments. Resident #187 was 230 pounds. Record review of Resident #187's care plan dated 09/10/24 indicated potential for impaired skin integrity as evidence by Braden scale for predicting pressure ulcer risk, high risk for pressure ulcer. Intervention included provide skin care per facility guideline and as needed. During an observation on 09/16/24 at 9:09 a.m., Resident #187 was lying in bed on a pressure-relieving mattress. Resident #187's pressure-relieving mattress was set on 50 pounds. During an observation on 09/17/24 at 8:19 a.m., Resident #187 was sitting in her wheelchair bedside the bed. Resident #187's pressure-relieving mattress was set on 50 pounds. During an interview on 09/18/24 at 10:41 a.m., RN G said she did not know who was ultimately responsible for the monitoring the bed settings on the pressure relieving mattresses. She said when she hired on, she was told the nurses were responsible for checking the bed settings. She said she did not know Resident #36 and Resident #187's bed settings were on the wrong weight bed settings. She said wrong bed settings placed residents at risk for bed sores, wounds, or discomfort. She said it could negatively affect the residents by needing wound treatment and experiencing pain. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 11:02 a.m., RN S, the wound care nurse, said she guessed she was responsible for the bed setting in the pressure-relieving mattresses. She said the nurse who placed the resident on the pressure-relieving mattress was also responsible for the bed setting being correct. She said she knew Resident #36 had a pressure-relieving mattress but did not know Resident #187 had one. She said Resident #36 had moisture-associated skin damage, surgical incisions, and venous wounds to his lower legs. She said resident with high Braden scores also benefited from pressure relieving mattresses. She said residents placed on the wrong bed setting could cause bed sores due to the increased pressure or not enough pressure. She said the weight bed settings for Resident #36 and Resident #187 were wrong. She said pressure relieving mattresses being on the correct weight bed settings was important to prevent pressure ulcers and prevented further skin damage if a resident had a pressure ulcer. During an interview on 09/18/24 at 1:11 p.m., LVN Q said the nurses were responsible for bed settings on the pressure-relieving mattresses. She said she did not check Resident #36 or Resident #187's bed settings yesterday (09/17/24). She said Resident #36 and Resident #187's weight bed settings of 50 pounds and 350 pounds were not correct. She said incorrect bed settings could cause bed sores and wounds. She said it could negatively affect the resident by delaying the healing process and experiencing pain. During an interview on 09/18/24 at 1:44 p.m., LVN R said she did not know who was responsible for checking resident's bed setting. She said pressure relieving mattresses were important to prevent bed sores and skin breakdown. She said if the bed settings were incorrect, residents could develop pressure ulcers and injury, and be uncomfortable. During an interview on 09/18/24 at 3:54 p.m., the DON said she started at the facility July 13, 2024. She said the nurses were responsible for ensuring the pressure-relieving mattresses were on the correct bed settings. She said nursing management should be ensuring the nurses were checking the bed settings. She said the correct bed settings on the pressure relieving mattresses helped relieve pressure for residents with skin breakdown or at risk for it. She said residents on the wrong weight bed settings could cause skin alteration. During an interview on 09/18/24 at 4:30 p.m., the ADM said residents should be on the correct bed setting. He said resident not on incorrect weight bed setting placed resident at risk for unnecessary pressure ulcers. Record review of a facility's Prevention of Pressure Injuries policy revised 04/2020 indicated .support surfaces and pressure redistribution .select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 5 residents (Resident #2) reviewed for appropriate treatment and services to prevent urinary tract infections (an infection in any part of the urinary system, the kidneys, bladder, or urethra (is a hollow tube that lets urine leave your body)). The facility failed to ensure LVN Q documented Resident #2 had red-tinged urine (a urinary tract infection (UTI) is one of the most common causes of blood in your urine) in his indwelling catheter (drains urine from your bladder into a bag outside your body). The facility failed to ensure LVN Q reported to LVN M that Resident #2 had red-tinged urine in his indwelling catheter. The facility failed to ensure LVN Q reported to MD T Resident #2's red-tinged urine after Resident #2 had reported increased confusion and elevated white blood cell count. These failures could place residents at risk for untreated urinary tract infections. Findings included: Record review of Resident #2's face sheet dated 09/16/24 indicated Resident #2 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including sepsis (is a serious condition in which the body responds improperly to an infection) due to enterococcus (gram-positive, sphere-shaped (coccal) bacteria), megaloureter (an enlarged ureter), acquired absence of left leg above knee, and obstructive (occurs when urine cannot drain through the urinary tract) and reflux (is kidney scarring caused by urine flowing backward from the bladder into a ureter and toward a kidney) uropathy. Record review of Resident #2's admission MDS assessment dated [DATE] indicated Resident #2 was understood and usually understood others. Resident #2's BIMS score was 11 which indicated moderately cognitive impairment. Resident #2 admission performance requirement was substantial assistance for lower body dressing, partial assistance for personal hygiene, upper body dressing, shower/bathe self and toilet hygiene, and supervision for oral hygiene. Resident #2 had an indwelling catheter and occasionally bowel incontinence. Resident #2 had active diagnoses including septicemia (is bacteria in the blood (bacteremia) that often occurs with severe infections) and urinary tract infection (is an infection in any part of the urinary system. The urinary system includes the kidneys, ureters, bladder, and urethra) in the last 30 days. Record review of Resident #2 care plan dated 08/30/24 indicated Resident #2 had a foley catheter related to obstructive uropathy. Intervention included monitor/record/report to MD for signs and symptoms urinary tract infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating patterns. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress note dated 09/13/24 at 9:27 p.m., by LVN M indicated .resident noted with more confusion than usual .note sent to MD T for order for urinalysis (is a set of tests that looks at the appearance of your pee (urine) and checks for blood cells, proteins and other substances in it) on Monday .lab don't do stat urinalysis . Record review of Resident #2's progress note dated 09/13/24 at 11:13 p.m., by LVN M indicated .per MD T, no urinalysis for now unless resident develop fever, flank pain, abdominal pain .call MD T if resident develop low blood pressure, fever, or tachycardia . Record review of Resident #2's progress note dated 09/16/24 at 2:51 p.m., by LVN R indicated .MD T notified of critical lab results white blood cell 15.4 (the normal white blood cell count ranges between 4,000 and 11,000 cells per microliter) . Record review of Resident #2's progress note dated 09/17/24 at 12:19 p.m., by LVN Q indicated . genitourinary (is a word that refers to the urinary and genital organs) .urine clear yellow . Record review of Resident #2's progress note dated 09/17/24 at 1:35 p.m. by LVN Q indicated .spoke with MD T regarding labs .new order to redraw complete blood count (is a blood test that measures many different parts and features of your blood, including: red blood cells, which carry oxygen from your lungs to the rest of your body. [NAME] blood cells, which fight infections and other diseases) in AM . Record review of Resident #2's progress note dated 09/17/24 at 2:46 p.m. by LVN Q did not reveal assessment of Resident #2's genitourinary system. LVN Q did not document Resident #2 had pink-tinged urine. Record review of Resident #2's progress note dated 09/17/24 at 6:24 p.m., by LVN M indicated .5:30 p.m. resident noted in his room shaking, sweaty, respirations over 40 .oxygen started via nasal cannula .blood pressure 171/55 .pulse 115 .resident was sent to emergency room for evaluation . Record review of Resident #2's emergency department records dated 09/17/24 indicated .per nursing home EMS patient [Resident #2] has been altered for the past month .they state that over the last couple days he seems to have been declining more .today nursing staff checked on patient and found diaphoretic (producing perspiration) with respiratory rate greater than 40 and oxygen saturation 60% on room air .foley in place draining cloudy urine .WBC 27.8 . Record review of Resident #2's emergency department blood culture dated 7:18 p.m., indicated .positive gram-negative rods . Record review of Resident #2's emergency department urinalysis results dated 09/17/24 at 9:04 p.m., indicated .color: yellow .appearance: slightly cloudy (Abnormal) .Blood: large (abnormal) . Record review of Resident #2's emergency department urine culture results dated 09/17/24 at 9:04 p.m., indicated .RBC: too numerous to count .WBC: Moderate 11-25 (Abnormal) .Bacteria: Many greater than 50 (Abnormal) .culture urine: gram negative rods . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's hospital records dated 09/18/24 indicated .primary hospital problem: urinary tract infection .septic shock .per family member at bedside, patient's foley was exchanged in the emergency department with hematuria (is blood in your urine) noted . During an observation and interview on 09/16/24 at 9:13 a.m., Resident #2 was standing up then sat down on his bed. Resident #2 was attempting to remove his pants. Resident #2 was slow to respond to questions and appeared confused. Resident #2's indwelling catheter bag was on his bed, and he kept lifting the bag above his bladder. During an observation and interview on 09/17/24 at 8:19 a.m., Resident #2 was standing in his room holding the catheter bag above his bladder. Resident #2's catheter tubing was coming out at the top of his pants instead of below. Resident #2 had strawberry colored urine with segmentation or thick yellow substance in the catheter tubing. Resident #2 was slow to respond to questions and appeared confused. During an observation on 09/17/24 at 11:10 a.m., Resident #2 was pushing his wheelchair with his catheter bag in the seat. Resident #2 had strawberry colored urine with segmentation or thick yellow substance in the catheter tubing and chamber. During an interview on 09/18/24 at 1:11 p.m., LVN Q said she noted Resident #2 had pink-tinged urine around shift change. She said she worked the 6am-2pm shift on 09/17/24. She said she did not notice any yellow substance in Resident #2's indwelling catheter. She said she did not document Resident #2's pink-tinged urine because it was at shift change, but she did pass it on the LVN M. She said she had spoke with MD T in the morning about the critical WBC results but had not notified him about the pink-tinged urine. She said Resident #2 had periods of confusion and did not feel like he was acting out of norm. She said she was not aware LVN M had contacted MD T last Friday (09/13/24) about increased confusion and when he wanted an urinalysis drawn. She said increased WBC count, pink-tinged urine, and confusion could indicate a resident had a urinary tract infection. During an interview on 09/18/24 at 1:44 p.m., LVN R said the doctor should be notified of significant changes in condition. She said even though MD T was aware of Resident #2's increased WBC count and confusion, the new symptom of pink-tinged urine should have been reported to him. She said Resident #2's symptoms could indicate he had a possible urinary tract infection. She said not reporting symptoms of a possible urinary tract infection placed resident at risk for sepsis. She said it could negatively affect the resident by needing antibiotics or hospitalization . On 09/18/24 at 2:22 p.m., called MD T's office and left message with office staff for a return phone call. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 2:30 p.m., LVN M said she received report from LVN Q on 09/17/24. She said LVN Q reported Resident #2 had an elevated WBC count and MD T ordered a redraw in the morning. She said LVN Q did not report Resident #2 had pink-tinged urine and was not documented in the 24-hour report. She said last Friday (09/13/24), she noticed Resident #2 had increased confusion. She said she notified MD T of Resident #2's increased confusion and possible urinary tract infection. She said Resident #2 did not have a fever and a urinalysis could not be stat. She said MD T placed the urinalysis on hold because his vital signs were stable at the time. She said she would have contacted MD T if she had been aware Resident #2 had pink-tinged urine. She said Resident #2's symptoms of confusion, critical WBC results, and pink-tinged urine indicated a possible urinary tract infection. She said an untreated urinary tract infection could lead cause the resident to become septic. She said not reporting Resident #2's new symptom of pink-tinged to the doctor delayed treatment. She said on 09/17/24, Resident #2 had increased confusion and wanted to place paper towels in his prosthetic leg. She said about 5:15 p.m. on 09/17/24, CNA U came and got her to assess Resident #2. She said when she arrived Resident #2 was sweaty and had increased respiration and work of breathing. She said she placed oxygen on Resident #2 and tried to obtain vital signs, but he was too distressed to get a reading. She said she called 911. She said she placed Resident #2 on 4 liters and finally got an oxygen saturation of 76%. During an interview on 09/18/24 at 3:00 p.m., MD T said the facility did not notify him that Resident #2 had pink-tinged urine. He said he would have expected the nursing staff to have notified him immediately. He said if Resident #2 vital signs were stable when the facility had notified him of the new symptom, he would have ordered a urinalysis. He said if Resident #2's vital signs had not been stable then he would have sent Resident #2 out. He said which was what happened. He said he was notified Resident #2 was sweaty with increased respirations. He said Resident #2's symptoms of confusion, increased WBC, and pink-tinged urine individually may not have caused extreme concern, but all three symptoms together were a cause for concern. During an interview on 09/18/24 at 3:54 p.m., the DON said LVN Q notified her Resident #2 had pink-tinged urine. She said she could not recall what time LVN Q notified her. She said LVN Q should have passed the information on to the next shift and documented it on the 24-hour report. She said Resident #2 messed with his catheter and it was not the first time he had pink-tinged urine. She said they felt like the discolored urine was from manipulation. She said Resident #2 was a sickly man and had been admitted to the facility with a history of urinary tract infection. She said she did not really feel like due to his history of urinary tract infection he should have been closely monitored for another one. She said MD T could have been notified of the pink-tinged urine, but he was aware of the symptoms of confusion and elevated WBC. She said if a resident experienced an acute change of condition, then the MD should be notified. She said the nurse who found the issue, should notify the doctor. She said not notifying the MD of changes in condition could affect the resident in a poor way. She said she did not feel like LVN Q not reporting Resident #2 pink-tinged urine delayed his treatment. During an interview on 09/18/24 at 4:30 p.m., the ADM said he expected nursing staff to notify the physician with changes of condition. He said not notifying the physician with changes could have long term effects on the resident and delay treatment of the resident's symptoms. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Catheter Care, Urinary policy revised 08/2022 indicated .the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .observe the resident for complications associated with urinary catheters .report unusual findings to the physician or supervisor immediately .if urine has unusual appearance (example, color, blood, etc.) .if signs and symptoms of urinary tract infection or urinary retention occur .the following information should be recorded in the resident's medical records .character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor .report other information in accordance with facility policy and professional standards of practice . Record review of a facility's Acute Condition Changes policy revised 03/2018 indicated .the physician will help identify individuals with significant risk for having acute changes of condition during their stay .for example, an individual with an indwelling urinary catheter who has had recurrent symptomatic urinary tract infections .the physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications .the nursing staff will contact the physician based on the urgency of the situation .the nurse and physician will discuss and evaluate the situation .the staff and physician will discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, medication regimen, and diagnostic test results .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 3 of 22 residents (Resident #8, Resident #48, and Resident #190) reviewed for respiratory care. 1. The facility failed to change the oxygen tubing for Resident #8. 2. The facility failed to ensure Resident #48's nasal cannula humidification bottle (aids in preventing a patient's airways from becoming dry) had water in it. 3. The facility failed to ensure LVN Q performed Resident #190's tracheostomy care using aseptic technique per the facility's policy. 4. The facility failed to ensure LVN Q performed Resident #190's tracheostomy care and cleaning per the facility's policy. 5. The facility failed to ensure LVN Q used the prescribed solution to clean Resident #190's tracheostomy site. These failures could place residents at risk for of respiratory infections. Findings included: 1. Record review of Resident #8's face sheet, dated 3/16/24 revealed a [AGE] year old female admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (a common lung disease that makes it difficult to breathe), Osteoporosis (a bone disease that causes bones to become brittle and break easily), Anxiety Disorder (A mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities.) Record review of Resident #8's quarterly MDS assessment, dated 08/28/24, revealed Resident #8 had a BIMS of 99, which indicated she was unable to complete the BIMS test. Shows that resident #8 requires extensive assistance with ADLs. Record review of an order for Resident #8, dated 3/18/23, shows that staff were to, Change O2 tubing/water every week on Friday and PRN .Every night shift every Friday related to pneumonia. During an interview on 9/18/24 at 3:15 p.m., the DON said that it was the responsibility of facility nurses to ensure that residents oxygen tubing was changed per orders and labeled with the new date. She stated that residents could be placed at risk for respiratory infections if their oxygen tubing was not changed properly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/18/24 at 3:30 p.m., the ADM said that it was the responsibility of nursing staff to change the oxygen tubing for oxygen concentrators as it was ordered. He said that residents could be placed at risk for respiratory infections if they were not supplied with clean oxygen tubing. 2. Record review of Resident #48's face sheet dated 09/23/24 indicated Resident #48 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), cardiomegaly (is when your heart is abnormally thick or overly stretched, becoming larger than usual, with difficulty pumping blood), and atrial fibrillation (is an irregular heart rhythm that begins in your heart's upper chambers (atria)). Record review of Resident #48's quarterly MDS assessment dated [DATE] indicated Resident #48 was usually understood and usually understood others. Resident #48's BIMS score was 06 which indicated severe cognitive impairment. Resident #48 required moderate assistance for toilet hygiene, shower/bathe self, dressing, and personal hygiene, and supervision for oral hygiene. Resident #48 received oxygen therapy. Record review of Resident #48's care plan dated 07/02/24 indicated Resident #48 had oxygen therapy related to congestive heart failure and ineffective gas exchange. Intervention included oxygen settings: the resident has oxygen therapy via nasal cannula at 2 liters continuously, humidified. Encourage resident to keep nasal cannula in [NAME] for improved air exchange. During an observation and interview on 09/16/24 at 9:19 a.m., Resident #48 was sitting in her wheelchair beside her bed. Resident #48 was on 3.5 liter via a nasal cannula. Resident #48's humidification bottle was dated 09/07/24 and without water. Resident #48 said she did not know how long there had been no water in the bottle. Resident #48 said she thought her nose felt okay. 3. Record review of Resident #190's face sheet dated 09/16/24 indicated Resident #190 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including aneurysm of the ascending aorta (s a bulging, weakened area in the wall of a blood vessel resulting in an abnormal widening or ballooning greater than 50% of the vessel's normal diameter (width)), without rupture, presence of heart valve replacement, chronic obstructive pulmonary disease (is a common lung disease causing restricted airflow and breathing problems), encounter for attention to tracheostomy (is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), and Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of Resident #190's order summary report dated 09/18/24 indicated cleanse around tracheostomy daily or as needed using sterile water and prepared solution that is provided in trach care, one time day. Start date 09/05/24. Record review of Resident #190's order summary report dated 09/18/24 indicated trach care every shift and as needed. Start date 09/10/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #190's admission MDS assessment dated [DATE] indicated Resident #190 was understood and understood others. Resident #190's BIMS score was 15 which indicated intact cognition. Resident #190's admission performance requirement was partial assistance for lower body dressing, shower/bathe self, and toilet hygiene, supervision assistance for upper body dressing, and set-up assistance for oral hygiene. Record review of Resident #190's undated baseline care plan indicated oxygen therapy and tracheostomy care. Resident #190's comprehensive care plan not due yet. During an observation and interview on 09/17/24 at 11:30 a.m., LVN Q performed tracheostomy care of Resident #190. Resident #190 sat in his wheelchair for the procedure. LVN Q washed her hands then placed on gloves. LVN Q opened the sterile trach kit with her gloved hands. LVN Q reached into the trach kit with a gloved hand and moved the sterile drape and pipe cleaners off to the side of the kit. LVN Q squeezed 4 saline bullets into the trach kit and moistened the gauze. LVN Q removed the gauze from under Resident #190 tracheostomy site. LVN Q removed gloves then washed her hands. LVN Q grabbed sterile gloves out of the trach kit and placed them on. LVN Q said the procedure was a clean procedure not sterile procedure in the nursing home. LVN Q grabbed the sterile drape and placed it on Resident #190's chest. The sterile drape slid down Resident #190's chest several times until LVN Q tucked the drape in Resident #190s shirt. The sterile drape was not under the trach site. LVN Q grabbed a long-tipped cotton applicator and moistened with normal saline then cleaned the inside of the tracheostomy hub (is the part that protrudes from the patient's neck) x2. Resident #190 excessively coughed both times. LVN Q then bent a pipe cleaner in half and cleaned inside the tracheostomy hub. Resident #190 excessively coughed during cleaning. LVN Q took a moistened 4x4 gauze and slide the gauze underneath the ride side of the tracheostomy flange (is the part of the tracheostomy tube that extends from the outer part of the tracheostomy tube and has holes to attach the tracheostomy tube tie) then a new 4x4 gauze underneath the left side. Resident #190 excessively coughed both times. Resident #190 then coughed out phlegm from his tracheostomy. LVN Q then bent another pipe cleaner in half and removed excess phlegm from Resident #190's tracheostomy hub. LVN Q then placed a new 4x4 split gauze around Resident #190's trach site. LVN Q then removed Resident #190's Velcro trach tube holder (is used to hold a tracheostomy tube in place. The collar connects to the tracheostomy plates, which work to stabilize the tube.) and applied a new one without another staff member. LVN Q did not remove the tracheostomy cannula and clean it with hydrogen peroxide and sterile water. LVN Q did not clean around the trach site with hydrogen peroxide and sterile water. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/18/24 at 1:11 p.m., LVN Q said the facility did an in-service on trach care before Resident #190 was admitted . She said trach care was a clean procedure in the nursing home setting. She said she did not know the physician order said to clean with sterile water and prepared solution in the trach kit. She said she always cleaned Resident #190's trach site with normal saline. She said she always cleaned the trach site and cannula with it in Resident #190. She said she did not know she was supposed to take the trach cannula out with trach care. She said the trach kit did have sterile gloves in it. She said the trach care kit became contaminated when she used the regular glove to move items. She said it was important to perform aseptic trach care to keep the resident infection free. She said when trach care was not performed correctly it place resident at risk for infection. She said she did not know the trach policy stated two people was required for changing the trach tube holder. She said two people were probably needed so one nurse could hold the trach in place, while the other staff member changed the holder. She said night shift was responsible for changing the respiratory equipment every 7 days. She said nasal cannulas got gross and nasty. She said when nasal cannulas were not changed every 7 days, it could cause infections. She said all nursing staff were responsible for keeping water in the humidification bottles. She said if water was not in the humidification bottle it could cause resident to have a dry nose. She said a dry nose could cause nose bleeds. She said she did not notice Resident #48's humidification bottle was dry on 09/16/24. During an interview on 09/18/24 at 1:44 p.m., LVN R said the nursing staff on 10pm-6am shift changed the oxygen tubing. She said the night shift nursing staff changed it weekly. She said it was important to change the oxygen tubing weekly for infection control. She said when nasal cannulas were not changed weekly it placed resident at risk for infection and the need for antibiotics. She said all staff should make sure water was in the humidification bottles. She said night shift nurse should place a new humidification bottle when the oxygen tubing was changed. She said using a nasal cannula without humidification could cause dry nasal passage and dry cough. She said it place residents at risk for nose bleeds and pain. During an interview on 09/18/24 at 3:54 p.m., the DON said a trach care in-service was given last year and when Resident #190 was admitted . She said all nursing staff were in-serviced with return demonstration. She said it was recommended to have 2 people when changing the trach holder but not required. She said she did not know if the facility's policy stated 2 people had to be present when changing the trach holder. She said she taught the nursing staff to clean around the trach site with sterile water or normal saline. She said sterile water should have been used for Resident #190's trach care if there was a physician order for it. She said items in trach kit should not be touched with non-sterile gloves. She said the trach kit became dirty when that happened. She said using items from a dirty trach kit placed resident at risk for infection. She said the infection was the negative outcome for staffing not performing trach care using aseptic technique (a method used to prevent contamination with microorganisms). She said nursing staff were only supposed to use the cotton-tipped applicators to clean inside the trach. She said using anything else to clean inside the trach could cause difficult breathing. She said LVNs were responsible for making sure water was in the humidification bottles. She said the CNAs should also monitor the water level and notify the LVNs. She said no humidification could cause dry mucous and nasal congestion. During an interview on 09/18/24 at 4:30 p.m., the ADM said that all staff should be ensuring residents had water in the humidification bottle. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of LVN Q's Trach Care and Suctioning/ Competency Checklist dated 09/23/23 indicated . demonstrates competency .able to perform trach care safely and effectively with sterile technique . understands what the various trach supplies are used for and how to properly use them .understands the procedure for replacing a trach tube . Record review of LVN Q's Trach Care and Suctioning Inservice dated 09/04/24 indicated .wash hands . assemble equipment and supplies .explain to patient what you are going to do .wearing gloves, remove and dispose of the soiled dressing .if pt has a disposable inner cannula, remove by squeezing clips on sides of inner cannula and dispose .wearing clean gloves, replace with new disposable cannula by clipping onto outer cannula .if pt has a non-disposable, remove by grasping outer cannula firmly and twisting inner cannula until it unlocks, place in a sterile basin of hydrogen peroxide to soak for 2 mins .use pipe cleaners and/or brush from trach care kit to clean inside tube .when clean, rinse in sterile basin of normal saline .wearing clean gloves, rinse again in another basin of normal saline to be sure peroxide is rinsed off .shake excess normal saline off tube but do not dry, small amount of normal saline is needed for reinsertion .replace clean non-disposable inner cannula, by holding outer cannula firmly and twisting inner cannula to locking position . using sterile cotton-tip applicators, dip in peroxide and use to clean under trach neck plate and around stoma opening .dispose of each applicator after use .continue this until foaming stops and area is clean .use sterile cotton-tip applicators, dip in normal saline bottle or sterile container and use normal saline to rinse off peroxide from under neck plate and around stoma area .dispose of each applicator after use .gauze with normal saline can also be used to clean and rinse the area .dry area with gauze, if needed .replace drain sponge underneath trach neck plate .if pt's trach holder is soiled, replace with a new one .have a 2nd person hold the trach tube securely in place while the holder is replaced .Do Not attempt to change the trach tube holder by yourself .passed trach care competency . Record review of facility policy titled Oxygen Administration revised in October of 2010 revealed that, The purpose of this procedure is to provide guidelines for safe oxygen administration Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration The date and time that the procedure was performed. Record review of the facility's Tracheostomy Care revised on 08/2013 indicated .the purpose of this procedure is to guide tracheostomy care and the cleaning of reusable cannulas .equipment and supplies: gloves (clean and sterile) .tracheostomy care kit .hydrogen peroxide .sterile water or normal saline .pulse oximeter .aseptic technique must be used: during cleaning and sterilization of reusable tracheostomy tubes . during all dressing changes until the tracheostomy wound has granulated (healed) .during tracheostomy tube changes, either reusable or disposable .sterile gloves must be used during aseptic procedures . 45643

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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** 45643 Based on observation, interview, and record review the facility failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs to meet the needs of 1 of 7 residents reviewed for pharmaceutical services. (Resident #17) Facility staff left Resident #17's medications at the bedside. These deficient practices could affect residents and place them at risk of not receiving the therapeutic dosage and drug diversion. The findings were: Record review of Resident #17's face sheet, dated 1/4/24 revealed a [AGE] year old female admitted on [DATE] with diagnoses that included Systolic Heart Failure (occurs when the left ventricle of the heart is too weak to pump enough blood to the body), Hypertensive Herat Disease (a constellation of changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation), Old Myocardial Infarction (a previous heart attack that's detected by an electrocardiogram (ECG) as pathologic Q waves in the heart). Record review of Resident #17's annual MDS assessment, dated 07/24/24. The MDS indicated a BIMS score of 12 indicating Resident #17's cognition was moderately impaired. The MDS indicated Resident #73 required partial assistance from staff for activities of daily living. Record review of Resident #17's Comprehensive Care Plan revised 07/17/24 revealed that Resident #17 was not care planned to administer her own medications. Record review of Resident #17's order for Gabapentin, dated 1/4/24 showed that Resident #17 was ordered Gabapentin two times a day for pain. During an interview and observation on 9/16/24 at 9:38 a.m. it was observed that Resident #17 had 1 dose of Gabapentin (white capsule numbered 216 identified as gabapentin) in a plastic medication administration cup. Surveyor asked Resident #17 if she knew she had medication that she had not taken in the cup. Resident #17 said she did not know she missed one of her pills. Resident #17 said she would not have known unless the surveyor had mentioned it. During an interview on 9/18/24 at 1:25 p.m., CMA K said when she administered medications, she would watch the resident take the medication before she left the room. She said staff shouldn't leave residents until they've taken or refused the medication because another resident could take the medication. She said leaving medications in a room could place residents at risk of taking medications that did not belong to them. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/24 at 3:15 p.m., the DON said the medication aide is responsible to ensure that residents take their medication or refuse them before they leave. She said that leaving medications would place other residents at risk of taking medications they were not prescribed. She said that residents that if a resident refused a medication the medication would then need to be discarded. During an interview on 9/18/24 at 3:30 p.m., the ADM said that the medication aide is responsible for administering medications. He said that any medication that was refused should be discarded and not left in the resident's room. He said that residents could be placed at risk for taking medications that did not belong to them if a medication was left unattended. Record review of the facility's policy Administering Medications, dated April of 2019, stated Medications are administered in a safe and timely manner, and as prescribed. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the medication administration records space provided for that drug and dose

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interview and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, residents who had not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 26 residents (Resident #287) reviewed for psychotropic medications. The facility failed to have an appropriate diagnosis or indication of use for Resident #287's Quetiapine (antipsychotic). These failures could put residents at risk of receiving unnecessary psychotropic medications. Findings included: Record review of a face sheet dated 9/17/2024 indicated Resident # 287 was an [AGE] year-old female who was admitted on [DATE] with diagnosis including dementia (a group of thinking and social symptoms that interferes with daily functioning), heart failure (a chronic condition in which the heart does not pump blood as well as it should) , atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), atherosclerotic heart disease of native coronary artery (the buildup of fats, cholesterol and other substances in and on the walls if the heart arteries) , anxiety (mental health condition that causes repeated episodes of intense fear or dread) and depressive episodes (mental disorder that causes a persistent feeling of sadness and loss of interest) Record review of Resident #287's MAR dated 9/1/2024- 9/30/2024 indicated Resident # 287 was taking Quetiapine Fumarate 25 mg 1 tablet by mouth twice daily related to unspecified dementia, mild with psychotic disturbances. Record review of the admission MDS dated [DATE] indicated Resident #287 was usually understood and usually understood by others. The MDS indicated Resident #287 had a BIMS score of 7 indicating she was severely cognitively impaired. The MDS indicated Resident #287 required setup assistance for eating and partial assistance for transfers, bed mobility, dressing, toilet use, personal hygiene, and bathing. The MDS indicated Resident # 287 was occasionally incontinent of bladder and always incontinent of bowel. The MDS indicated Resident #287 had received an antipsychotic in the last 7 days. Record review of Resident # 287's care plan dated 7/1/2024 indicated resident required antipsychotic medication for diagnosis of psychosis and depressive disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/2024 at 1:23 Pm, LVN F said the charge nurse was responsible for reconciling medications upon admission. LVN F said prior to administering an antipsychotic medication, a consent form must be signed by Physician and family. LVN F said a resident with dementia should not be prescribed an antipsychotic medication. She said depression and sleep was not an appropriate diagnosis for an antipsychotic medication. LVN F said she would clarify the diagnosis before administering an antipsychotic medication. LVN F said she would document clarification with the Physician in the nurse note but said some nurses will document calling Physician on the admission note. LVN F said a resident may get overly sedated and would place a resident at risk for falls. LVN F said she had been in-serviced on antipsychotic medications. During an interview on 9/18/2024 at 1:41 PM, RN G said a resident prescribed an antipsychotic medication should have a diagnosis of schizophrenia or bipolar disorder. RN G said she believed that dementia would be an appropriate diagnosis for an antipsychotic medication but admitted she would reach out to the physician for clarification if she suspected the diagnosis was incorrect. During an interview on 9/18/2024 at 2:21 PM, MDS nurse H said a resident cannot be on an antipsychotic medication with a diagnosis of dementia. She said an appropriate diagnosis would be schizophrenia, Huntington, bipolar or Tourette syndrome. MDS Nurse H said if a resident came to the facility on Quetiapine, we would reach out to the Physician to clarify the appropriate diagnosis. She said the facility made sure the residents have the correct diagnosis of we discontinue the medication if the Physician agrees. MDS Nurse H said the charge nurse was responsible for ensuring the diagnosis was correct on the resident chart if on the weekend. MDS Nurse H said we do have pharmacy recommendations prior to admission. MDS Nurse H said antipsychotics prescribed for sleep, depression and dementia are not an appropriate diagnosis and could negatively impact the resident. The MDS Nurse H said normally, there would be a PASSR if the resident needed an antipsychotic and could get additional benefits. During an interview on 9/18/2024 at 2:30 PM, MDS Nurse J said she does not complete the consent form for antipsychotic medications and said the nurse on the unit completed the consent, During an interview on 9/18/2024 at 2:45 PM, the ADON said it was appropriate to prescribe antipsychotic medications to a resident with dementia if the resident had behaviors. The ADON said other appropriate diagnosis would be schizophrenia. The ADON said all the nurses and administrative staff are responsible for reviewing medications. She said the MDS nurses would also review the medications to ensure the resident had the proper diagnosis. The ADON said she would clarify a medication if she suspected the diagnosis was incorrect. The ADON said the pharmacy also completes a consultation report and they review the medications. The ADON said the nurse on the unity would be documenting in the progress note if the physician was contacted for the appropriate dosages. She said if the nurse does not receive a response, we pass on the information in report. The ADON said antipsychotic medications administered could cause falls or other things if a resident was administered antipsychotic and did not have the proper diagnosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/2024 at 2:53 PM, the DON said it was a team effort and the charge nurse, MDS nurse, ADON were responsible for ensuring the medication review and resident had the appropriate diagnosis for medication. The DON said the Physician prescribes it. The DON said it was appropriate for the medication Quetiapine to be prescribed and ordered for a resident had unspecified dementia with psychotic disturbances. The DON said Resident # 287 was admitted with Quetiapine and it was prescribed by the hospice company, and they do not have to follow CMS guidelines and are not under Long-term care. The DON said she was not at the facility at the time of Resident #287's admission and was not aware Resident #287 was on Quetiapine. She said she would expect the charge nurse or ADON to address the diagnosis on residents with antipsychotic medication with a diagnosis of dementia to clarify. The DON said antipsychotic medications could cause side effects to the resident. The DON was not able to provide a copy of the facility policy for psychotropic medication use. During an interview on 9/18/2024 at 3:54 PM, the ADM said he was familiar with the policy on antipsychotics, and they have different types of behaviors or symptoms. The ADM said it was appropriate for a resident with a diagnosis of dementia to be on an antipsychotic. He said the nurses were responsible for clarifying the diagnosis with the physician. The ADM said he believes a nurse should document in the progress note if Physician was notified or clarification was needed. The ADM said you do not want to treat someone that is not appropriate if they have the incorrect diagnosis and said there could be side effects of the medications. Record review of Pharmacy Consultation dated 7/17/2024 indicated Resident # 287's medication was reviewed for Antipsychotic medication Quetiapine. The review indicated the diagnosis on the order was for depression and was not an approved indication per CMS. The Pharmacist consultant recommended consideration of alternative therapy. Record review of Resident #287's consent for psychotropic medication treatment, dated 7/1/2024 indicated Quetiapine was prescribed for diagnosis of major depressive disorder and dementia with psychotic disturbances. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review of facility policy dated July 2017 titled Reconciliation of Medication on Admission indicated the purpose of this procedure was to ensure medication safety by accurately accounting for the resident's medication, routes and dosages upon admission or readmission to the facility. General guidelines . 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescriptions .2. Medication reconciliation reduces medication errors and enhances the resident safety by ensuring the medication the resident needs and has been taking .3. Medication reconciliation helps ensure that all medications, routes, and dosages on the list are appropriate for the resident and his/her condition .4. Medication reconciliation helps to ensure that medications, routes, and dosages have been accurately communicated to the Attending Physician and care team. Steps of Procedure .5. Review the list carefully to determine if there are discrepancies or conflicts .5. c. There is a medication listed on the discharge summary for which there is no diagnosis or condition to support the use of the medication .6. If there is a discrepancy or conflict in medication dose, route, or frequency, determine the most appropriate action to resolve . c. discuss with the resident family, d. contact the resident's primary physician in the community f. contact the community pharmacy used by the resident or g. contact the admitted and or Attending Physician. Documentation .1. Document the medication discrepancy on the medication reconciliation form .2. Document the actions were taken by the nurse to resolve the discrepancy .3. If the discrepancy was unresolved, document how the discrepancy was communicated to the charge nurse, physician, pharmacy and or next shift. 4. If the discrepancy was resolved, document how the discrepancy was resolved.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 5 residents (Residents #36) reviewed for pharmacy services. The facility failed to ensure Resident #36 Levothyroxine (is used to treat hypothyroidism, a condition where the thyroid gland does not produce enough thyroid hormone) and Pantoprazole (is used to treat heartburn and certain other conditions caused by too much acid in the stomach) were scheduled and administered for optimal therapeutic effect (is a consequence of the medical treatment of any kind, the results of which are judged to be desirable and beneficial). This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of Resident #36's face sheet dated 09/16/24 indicated Resident #36 was an 85-years-old, male admitted to the facility on [DATE] and 09/04/24 with diagnoses including hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormone) and gastro-esophageal reflux disease (is a condition in which the stomach contents leak backward from the stomach into the esophagus (food pipe)). Record review of Resident #36's admission MDS assessment dated [DATE] indicated Resident #36 admission entry date was 09/04/24. Resident #36 was understood and understood others. Resident #36 had a BIMS score of 08 which indicated moderately cognitive impairment. Resident #36's admission performance requirement was substantial assistance for toilet hygiene, shower/bathe self, and lower body dressing, partial assistance for upper body dressing and personal hygiene, and supervision for oral hygiene. On 09/17/24 at 9:30 a.m., the DON provided a baseline care plan for Resident #36. The baseline care plan was dated 07/05/24 which was the previous admitted . The facility did not provide a baseline care plan for admitted [DATE]. Record review of Resident #36's order summary report dated 09/18/24 indicated: *Levothyroxine Sodium Oral Tablet, give 200 mcg by mouth one time a day related to hypothyroidism. Start date 09/05/24. *Pantoprazole Sodium Oral Tablet Delayed Release 40mg, give 1 tablet by mouth one time a day related to gastro-esophageal reflux disease. Start date 07/23/24. Record review of Resident #36's medication administration record dated 09/01/24-09/30/24 indicated: *Levothyroxine Sodium Oral Tablet, give 200 mcg by mouth one time a day related to hypothyroidism. Start date 09/05/24. Scheduled at 0800. Doses received 09/05/24-09/16/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Pantoprazole Sodium Oral Tablet Delayed Release 40mg, give 1 tablet by mouth one time a day related to gastro-esophageal reflux disease. Start date 07/23/24. Scheduled at 0900. Doses received 09/05/24-09/16/24. During an interview on 09/18/24 at 10:41 a.m., RN G said thyroid medications were supposed to be given before breakfast or 30 mins before a meal. She said thyroid medications should not be given with other medications. She said pantoprazole should be given at least 30 minutes before meals. She said pantoprazole was not effective if given after meals. She said the admit nurse or the nurse who received the medication order for Resident #36, should have scheduled the medications at optimal times if not specified by the MD. She said giving thyroid or acid reducing medications at the wrong times could make the medication ineffective, not receive the proper benefits, and experience adverse reactions. She said anyone that noticed the medication not scheduled at the correct time should have gotten orders to fix it. During an interview on 09/18/24 at 11:18 a.m., MA V said thyroid medication was normally given before her 6am shift started. She said lately she was given thyroid medication at 8am. She said thyroid medication was supposed to be given on an empty stomach and not with other medications. She said pantoprazole was normally given before meals. She said pantoprazole helped prevent acid reflux. She said thyroid medication was not effective if given with other medication. She said giving the medication at the wrong times defeated the purpose of the medication. She said resident could feel sick and nauseated when medications were given at the wrong times. During an interview on 09/18/24 at 1:11 p.m., LVN Q said the nurse who takes the medication order timed the medication. She said thyroid medications were normally scheduled on the 10pm-6am shift. She said thyroid medications should be given without food and on an empty stomach for better absorption. She said reflux medication should be given 1 hour before meals. She said given it before meals helped stop reflux. She said when a thyroid medication was given at the wrong time, it did not treat the thyroid problem. She said when a reflux medication was given after meals, the resident could experience reflux symptoms. She said she did not know Resident #36's levothyroxine and pantoprazole were scheduled at 8am and 9am. She said the MAs normally gave those medications. During an interview on 09/18/24 at 3:54 p.m., the DON said thyroid medications were normally scheduled at 5 a.m. and 4:30 a.m. She said the thyroid medication was not effective if given with other medication and with food. She said acid reflux medications were normally scheduled 30 minutes to 1 hour before meals. She said it was important to give it before meals due to how the medication worked to reduce acid reflux. She said Resident #36's levothyroxine and pantoprazole scheduled at 8 a.m. and 9 a.m. was not therapeutic. She said the nurses scheduled the medication on the medication administration record. She said nurse management was responsible for ensuring resident's medications were scheduled as ordered and at appropriate times. She said there was not a process in place to review medication times. She said the facility would start auditing medication administration records for schedule times. During an interview on 09/18/24 at 4:30 p.m., the ADM said medications should be timed to be most effective to the resident. He said giving thyroid and acid reflux medication with food was not effective. He said the resident would not receive the benefits of the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Administering Medications policy revised on 04/2019 indicated .medication administration times are determined by resident need and benefit, not staff convenience .factors that are considered included: enhancing optimal therapeutic effect of the medication .prevent potential medication or food interactions . Review of Clinical Thyroidology for Patients (April 2011) by [NAME], MD, https://www.thyroid.org/patient-thyroid-information/ct-for-patients/vol-4-issue-5/vol-4-issue-5-p-7/ was accessed on 09/25/2024 indicated it is well documented that food and a number of medications can decrease the absorption of levothyroxine .consequently, many patients are instructed to take their levothyroxine on an empty stomach before breakfast and to wait up until an hour before eating . Review of National Library of Medicine: Morning and evening administration of pantoprazole (June 1997) by Mussig S, [NAME] L, [NAME] R, [NAME] A., https://pubmed.ncbi.nlm.nih.gov/9222733/ was accessed on 09/25/2024 indicated .the drug being given as either a morning or an evening dose before meals .the study supports the recommendation of once-daily morning dosage regimen of pantoprazole 40 mg in the treatment of acid-related diseases .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation in that: 1. Dietary Manager not properly securing facial hair. 2. Particles on top of dishwasher. 3. Grease buildup on the left side of gas stove and grease [NAME]. These deficient practices could place residents who received meals from the kitchen at risk for food borne illness. The findings were: 1. During an observation on 9/16/2024 at 8:55 AM, the dietary manager was not wearing proper facial covering upon entry into the kitchen. During an observation on 9/17/2024 at 8:19 AM, the dietary manager was not wearing facial covering. During an observation and interview on 9/18/2024 at 9:50 AM, Dietary Aide A said everyone should be wearing hair covering while entering the kitchen. She said males should have their facial hair covered and no hair should be sticking out of the hair net. Dietary Aide A said the kitchen staff were to secure hair with hairnets as soon as walking in the kitchen. Dietary Aide A said a resident could negatively be impacted if they had hair in their food. During an interview on 9/18/2024 at 9:52 AM, Dietary [NAME] B said everyone should be wearing hairnets as soon as they enter the kitchen and hair should be tucked in properly. She said males should be wearing facial restraints. Dietary [NAME] B said hair could fall out on a resident's food and make them sick. Dietary [NAME] B said the Dietary Manager was responsible for ensuring everyone was wearing hair nets correctly. Dietary [NAME] B said a resident could get upset if they found hair in their food. During an interview on 9/18/2024 at 10:05 AM, the Dietary Manager said everyone should be wearing hairnets and men should be wearing facial covering. The Dietary Manager said mustache were supposed to be covered. He said the current facial coverings provided by the facility fall off his face. He said he had notified the previous Dietary Manager and the ADM that the facial restraint provided, did not properly fit him. The Dietary Manager said the previous Dietary Manager and ADM advised him to look at the supplies on his computer and find a different covering that fit properly. The Dietary Manager said no hair should be sticking out of hair restraints or at the base of the neck. The Dietary Manager said hair could contaminate the food and he was responsible for ensuring all staff were wearing their hairnets properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/18/2024 at 2:53 PM, the DON said the ADM was over the Dietary Manager. The DON said she expected the kitchen staff to wear hair nets properly. She said if a male kitchen staff had long or short beard, they should be wearing a facial covering. The DON said she was not sure if the facial covering should be on only when handling food or while cleaning the kitchen. During an interview on 9/18/2024 at 3:54 PM, the ADM said all kitchen staff should be wearing hair nets and facial covering for the male staff if they have facial hair, beards, and mustache. The ADM said the hair restraints should be secured while in the kitchen. He said the Dietary Manager was responsible for ensuring kitchen staff were properly hair nets and facial restraints. The ADM said not securing the hair could contaminate the food with loose hair. 2. During an observation and interview on 9/18/2024 at 9:50 AM, Dietary [NAME] A said the cook was responsible for the oven and [NAME] and she was not sure how often it was supposed to be cleaned. During interview, observed the top of dishwasher covered with food particles. The Dietary Aide A said she cleans the dishwasher everyday but there was not a checklist she marked completed. Dietary Aide A said the top of the dishwasher did not appear clean and she was not sure when it was last cleaned. She said the food particles on the top of dishwasher could blow on the clean dishes and could make a resident sick. During an observation and interview on 9/18/2024 at 9:52 AM, Dietary [NAME] B said the kitchen staff are supposed to clean the oven and [NAME]. Dietary [NAME] B said the Dietary Manager cleaned the [NAME]. Dietary [NAME] B said there was a checklist on a clip board in the kitchen of daily duties. Dietary [NAME] B said grease build up on the oven could spark a fire and said it would not cause any harm to resident's because they were not in the kitchen. Dietary [NAME] B said she was not sure if a foodborne illness could happen if grease or oil was not properly cleaned out. She said she thought it could make someone sick. Dietary [NAME] B said the oven and stove were only serviced when there was something wrong with it. Dietary [NAME] B provided the kitchen cleaning schedule for September titled Magnolia Place Dietary Department indicated cleaning schedule not initialed and black mark through the Dietary Aide Side, Sunday through Saturday schedule. During an interview on 9/18/2024 at 10:05 AM, the Dietary Manager said he was responsible for the cleaning of the [NAME] every Friday. He said he does not document the cleaning and does not have a checklist for the [NAME]. The Dietary Manager said the cook was responsible for cleaning the oven and the night cook was the one who should be cleaning oven. The Dietary Manager said there was a cleaning schedule hanging on the clipboard in the kitchen. He said the kitchen staff should be checking the checklist before leaving for the evening. The Dietary Manager said he does go behind the kitchen staff to ensure the cleaning was completed. The Dietary Manager said he was aware of the food particles on the dishwasher and said he was not sure how it keeps getting buildup of particles. The Dietary Manager said the food particles on top of the dishwasher and on the [NAME] could contaminate the clean dishes or food with potential to make a resident sick. During an interview on 9/18/2024 at 2:53 PM, the DON said kitchen staff are responsible for keeping the oven, [NAME] and dishwasher clean. She said she was not sure about the kitchen cleaning schedule. The DON said she would expect there to be a schedule in place and a checklist to be initialed if the cleaning was completed. The DON said she would expect the Dietary Manager to go behind the kitchen staff the cleaning was completed. The DON said she could not speak to if grease buildup on the side of the oven and [NAME] would cause a fire. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/18/2024 at 3:54 PM, the ADM said everyone in the kitchen was responsible for cleaning the oven, [NAME] and dishwasher. The ADM said there should be a checklist indicating what needs to be cleaned and should be completed daily. The ADM said he felt just checking a list was fine for now but said he would visit initialing the checklist and discuss with the Dietary Manager. During an interview on 9/19/2024 at 11:32 AM, the Dietician said she was just notified State was in the building. The Dietician said she would provide the cleaning schedule and facility policies for cleaning schedule and employee sanitation. During record review of facility kitchen checklist dated September titled Magnolia Place Dietary Department indicated cleaning schedule not initialed and black mark through the Dietary Aide Side, Sunday - Saturday schedule. Prep Workstation checklist indicated .clean microwave after each meal service, keep overhead shelf cleaned and polished weekly, keep counter clean from buildup and polish weekly, clean crumbs from toaster after each use, keep lower shelves clean from debris, spillage, and polish weekly, and keep drawers organized and free from dirt and grim. No observed initials or dates of completion from dietary staff or manager. During record review of the facility policy dated October 2018 titled Cleaning Schedule indicated the facility will maintain a cleaning schedule prepared by the Nutrition and Foodservice Manager and followed by employees as assigned in order to ensure the kitchen is clean and free of hazards .Procedure: 1. The Nutrition and Foodservices Manager will develop a cleaning schedule for daily, weekly and monthly cleaning . 2. Cleaning task will be assigned to positions and included in the job descriptions. 3. The cleaning list will be posted weekly and initialed off and dated by each employee upon completion of the task. The Nutrition and Foodservice Manager or designed will verify that the tasks were completed as assigned. During record review of facility policy dated October 1 , 2018 titled Employee Sanitation indicated .Policy . The Nutrition and Foodservice employees of the facility will practice good sanitation practices in accordance with the state and US food Codes in order to minimize the risk of infection and food borne illness . Procedure .Do not allow employees who have communicable diseases, who are carriers of communicable diseases, who have boils, infected wounds, sores or acute respiratory infection to work in any area of the kitchen .2. If the Nutrition and Foodservice Manager suspects that an employee has contracted a communicable disease . 3. Employee Cleanliness Requirements .a. All employees must wear clean outer clothing .b. Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces .