STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675851	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Georgia Manor Nursing Home	2611 W 46th Ave Amarillo, TX 79110

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491 Based on observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and failed to protect and promote the rights of the residents for one (Resident #8) of 12 residents reviewed for rights, in that: The facility failed to ensure Resident #8 felt safe within her room environment as well as her preference for TV volume were met. This failure could place the residents at risk for a diminished quality of life, well-being, and dignity. Findings included: Record review of Resident #8's admission record dated 4/15/24 revealed a [AGE] year-old female originally admitted to the facility on [DATE], with a more recent admitted [DATE]. Resident #8 had diagnoses that included, but were not limited to, COPD (chronic obstructive pulmonary disease which refers to a group of diseases that cause airflow blockage and breathing-related problems, Bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Anxiety disorder (a group of mental illnesses that cause constant fear and worry), and Polyneuropathy (malfunction of many peripheral nerve throughout the body). Record review of Resident #8's quarterly MDS completed on 02/20/2024 revealed a BIMS of 10 out of 15 which indicated her cognition was moderately impaired. Section GG of the MDS revealed that Resident #8 used a wheelchair and needs setup or clean up assistance for personal hygiene and showers. Section I of the MDS revealed an active diagnosis of Anxiety and Bipolar disorders. Record review of Resident #8's Care plan dated 03/08/2024 revealed the resident had an alteration in neurological status and staff were to encourage her to discuss any concerns and fears regarding diagnosis or treatments. The care plan further revealed that discharge from the facility was not feasible and that the staff are to respect resident's right to view nursing facility as her home. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's progress notes revealed on 04/01/24 that Resident #8 stated, I'm good. Further notes on that day reflected the resident had anxiety, and the resident was crying. The notes did not reflect anything regarding what her crying or anxiety was concerning. During an observation and interview on 04/14/24 at 9:52 Am, revealed Resident #8's roommate lying on her bed in her room, watching a very loud television. Privacy curtain was drawn between roommate and Resident #8. Interview with roommate revealed that she and Resident #8 had confrontations before, but she had only been in the facility about 10 days. Stated Resident #8's TV is too loud. During an observation and interview on 04/14/24 at 10:01 AM, revealed Resident #8 was lying on her left side in her bed with TV on, but within normal sound. Resident #8 started crying when she began to talk about her roommate. She stated that her roommate had cussed at her and that she could not hear her own TV. She went on to state that she had not slept for so long because she was afraid and because of her roommate's loud TV. She stated that she had not talked with anyone about the situation because she did not know who to talk to and she was afraid to do so. When asked if the Surveyor could talk with the SW for her, she stated yes. During an interview on 04/14/24 at 10:45 AM, the SW stated that she did not know Resident #8 was so upset, unhappy, and not sleeping. She went on to state that other residents that lived close to Resident #8's room had reported to her that the roommates were loud and that they go at each other . During an observation on 04/14/24 at 12:03 PM, the SW was observed talking with the roommate of Resident #8. The SW stated to Resident #8's roommate that she was helping to get her home health set up and that she would be able to be discharged to home tomorrow, 04/15/24. During an interview on 04/14/24 at 2:12 PM, the SW stated Resident #8's roommate was going home on 04/15/24 and that she had not had a chance to talk with Resident #8 about it yet, but the SW would see if Resident #8 could make it one more night in her room with her roommate. During an observation and interview on 04/15/24 at 11:30 AM, revealed Resident #8 was ambulating down the hall towards the dining room. She stated that last night staff moved her to a different room and that she had a very good night and slept well. Resident #8 stated she had just woken up. During an observation on 04/16/24 at 8:00 AM, revealed Resident #8 was lying on her back in her old room by herself, asleep. During an interview on 04/16/24 at 9:43 AM, the SW stated a possible negative outcome for the resident not getting sleep or feeling afraid because of a roommate or TV being too loud would be that it could cause depression in the resident and anxiety and could impact sleep. During an interview on 04/16/24 at 10:25 AM, the CN stated that a possible negative outcome for a resident not getting sleep or feeling afraid because of a roommate situation would be that it could cause a decrease in appetite, cause emotional distress and the resident could stop going to activities. During an interview on 04/16/24 at 10:35 AM, the ADON stated that a possible negative outcome could be that their blood pressure could go up as well as their anxiety because of lack of sleep and not feeling safe. She went on to state that lack of sleep is not good for anyone. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/16/24 at 10:47 AM, revealed Resident #8 was lying in her bed in her old room, sleeping on her right side. Resident #8 was in the room alone and observation of name plate outside door revealed that she no longer had a roommate. During Exit Conference on 04/16/24 at 3:40 PM, ADM gave Surveyor written statement from Resident #8's next door neighbor. The written statement stated, Friday night, Resident #8 and her roommate were fighting over the TV, and I heard the arguing and so did my roommate. They woke me up with the arguing and Resident #8 wanted the TV off and her roommate wanted it on, and it went on for a while. I heard Resident #8's roommate cussing at her, and Resident #8 said you shouldn't talk to me that way and Resident #8's roommate mocked her. Resident #8 told her roommate you will get in trouble, and roommate stated, so what. Record review of facility policy titled Resident Rights, dated 11/28/16 revealed the following: .Respect and Dignity - The resident has a right to be treated with respect and dignity, including: . 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. .Safe Environment - The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491 Based on interview and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 of 12 residents (Resident #32) whose MDS assessments were reviewed. Resident #32's MDS assessment indicated in Section B that his vision was adequate, and he did not have corrective lenses. This failure to ensure accurate assessments may place resident at risk for improper or inadequate care due to staff lack of knowledge about the resident's status, needs, strengths, and areas of decline. Findings include: Record review of Resident #32's face sheet dated 4/14/24 revealed a [AGE] year-old male with an original admitted [DATE] with a more recent admitted [DATE]. Resident #32 had diagnoses that included, but were not limited to: Pulmonary hypertension (high blood pressure that affects arteries in lungs and heart), Major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that causes happiness), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), Type 2 diabetes (inability to process sugar), Hyperlipidemia (high cholesterol), hypertension (high blood pressure), and heart failure. Record review of Resident #32's physician's orders revealed a prescription order dated 10/11/23 for corrective lenses. Record review of Resident #32's Annual MDS dated [DATE], Section B revealed resident had adequate vision and did not use corrective lenses. Section C of annual MDS dated [DATE] revealed the resident had a BIMS score of 13 which indicates he was cognitively intact. Record review of Resident #32's quarterly MDS dated [DATE], Section B revealed no mention of the need of corrective lenses or vision issues. Record review of Resident #32's Care Plan dated 03/08/24 revealed no mention of the resident having an issue with vision or needing or wearing prescription glasses. During an interview on 4/14/24 at 11:00 AM, Resident #32 stated that he got a prescription for glasses several months ago but never received his glasses. During an interview on 04/16/24 at 9:43 AM, the SW stated that she did Resident #32's social history recently and she did not know that he needed glasses since he had not worn any since she started working at the facility at the beginning of March 2024. The SW stated a possible negative outcome of not having glasses that were prescribed is that it could be detrimental to health. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with the MDS LVN on 4/16/24 at 9:59 AM, revealed observation of the MDS LVN opening Resident #32's MDS in the electronic health records. The Surveyor showed the MDS LVN physician's orders for a prescription for glasses. The MDS LVN stated that it was not her job to follow up on physician's visits or appointments. She went on to state that as far as she knew, she did not know he needed glasses. She stated a possible negative outcome for a resident not having glasses that were prescribed would be a decline in health. In an observation and interview on 4/15/24 at 10:10 AM, revealed Resident #32 was ambulating in the hallway, not wearing glasses. He stated he loved to read and had not been able to for a long time. He stated that he talked with the SW about needing glasses last week and nothing had happened. In an interview on 04/16/24 at 10:25 AM, the CN stated a possible negative outcome for a resident not having prescription glasses would be an increase in falls and not being able to participate in activities. She went on to state a possible negative outcome for not having an accurate MDS assessment would be lack of continuum of care. In an interview on 04/16/24 at 10:30 AM, the ADON stated a possible negative outcome for not having prescription glasses for resident would be that they could fall or run into things. If MDS assessment was not accurate for a resident, the possible negative outcome could be a lot of issues because it could affect everything planned for them while they are in the facility. In an interview on 04/16/24 at 11:08 AM, the SW stated that Resident #32 would be going today at 2:00 PM to pick out prescription glasses. In an observation on 04/16/24 at 3:48 PM during the exit conference between the CN and the MDS LVN revealed the MDS LVN stated to the CN that on the 7 day look back period, Resident #32 didn't have glasses and that the MDS was not coded wrong. The MDS LVN stated that there was no issue with the MDS because the resident did not need the glasses. Record review of facility provided policy titled, Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy, dated February 2021 revealed, in part: Purpose/Policy - the purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. Federal Regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status. 3. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

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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** 48491 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 12 residents (Resident #32) reviewed for comprehensive care plans in that: Resident #32 had a physician's order for prescription glasses that was not addressed in his care plan. This failure could place residents at risk of receiving care that is not person-centered, substandard, unable to meet their needs, or inadequate to prevent complications. The findings included: Record review of Resident #32's face sheet dated 4/14/24 revealed a [AGE] year-old male with an original admitted [DATE] with a more recent admitted [DATE]. Resident #32 had diagnoses that included, but were not limited to: Pulmonary hypertension (high blood pressure that affects arteries in lungs and heart), Major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that causes happiness), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), Type 2 diabetes (inability to process sugar), Hyperlipidemia (high cholesterol), hypertension (high blood pressure), and heart failure. Record review of Resident #32's physician orders revealed an order dated 10/11/23 for corrective lenses. Record review of Resident #32's Annual MDS dated [DATE], Section B revealed resident had adequate vision and did not use corrective lenses and quarterly MDS dated [DATE], Section B revealed no mention of need for corrective lenses or any vision issues. Record review of Resident #32's Care Plan dated 03/08/24 revealed no mention of resident having an issue with vision or needing or wearing prescription glasses. During an observation and interview with MDS LVN on 4/16/24 at 9:59 AM, observation of MDS LVN opening Resident #32's MDS in electronic health records. Surveyor showed MDS LVN physicians orders for a prescription for glasses. MDS LVN stated that is it not her job to follow up on physicians visits or appointments. She stated a possible negative outcome for resident not having glasses that were prescribed could be a decline in physical health. In an observation and interview on 4/15/24 at 10:10 AM, revealed Resident #32 was ambulating in the hallway, not wearing glasses. He stated he loved to read and had not been able to for a long time. He stated that he talked with the SW about needing glasses last week and nothing had happened. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/16/24 at 10:25 AM, the CN stated a possible negative outcome for resident not having prescription glasses would be an increase in falls and not being able to participate in activities. The CN went on to state that a possible negative outcome for not having an accurate care plan would be that the residents would not know what the plan for themselves would be and for staff not having a continuum of care. In an interview on 04/16/24 at 10:30 AM, the ADON stated a possible negative outcome for not having prescription glasses for a resident would be that they could fall or run into things and if there was not an accurate care plan for the resident, the possible negative outcome could be mishaps and that medications, follow up appointments, basically everything could be affected. Record review of facility provided policy titled Nursing Policy & Procedure Manual, dated 03/2018, with a subject of Comprehensive Care Planning revealed, in part, 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 time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491 Based on observation, interview, and record review, the facility failed to ensure that one (Resident #32) of 12 residents reviewed for vision services, received proper treatment and assistive devices to maintain vision abilities. The facility did not address Resident #32's need for prescription glasses following a physician's visit, for 6 months. This failure could affect residents by causing them to have decreased vision awareness when ambulating, difficulty seeing and participating in activities, and decreased self-esteem. Findings included: Record review of Resident #32's face sheet dated 4/14/24 revealed a [AGE] year-old male with an original admitted [DATE] with a more recent admitted [DATE]. Resident #32 had diagnoses that included, but were not limited to: Pulmonary hypertension (high blood pressure that affects arteries in lungs and heart), Major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that causes happiness), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), Type 2 diabetes (inability to process sugar), Hyperlipidemia (high cholesterol), hypertension (high blood pressure), and heart failure. Record review of Resident #32's physician's orders revealed a prescription order dated 10/11/23 for corrective lenses. Record review of Resident #32's Annual MDS dated [DATE], Section B revealed resident had adequate vision and did not use corrective lenses. Section C of annual MDS dated [DATE] revealed the resident had a BIMS score of 13 which indicates he was cognitively intact. Record review of Resident #32's quarterly MDS dated [DATE], Section B revealed no mention of the need of corrective lenses or vision issues. Record review of Resident #32's Care Plan dated 03/08/24 revealed no mention of the resident having an issue with vision or needing or wearing prescription glasses. During an interview on 4/14/24 at 11:00 AM, Resident #32 stated that he had gotten a prescription for glasses several months ago, but never received any glasses. During an interview on 04/16/24 at 9:43 AM, SW stated that she did Resident #32's social history recently and she did not know that he needed glasses since he had not worn any since she started working at the facility at the beginning of March 2024. Stated a possible negative outcome of not having prescribed corrective lenses could be detrimental to health. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with MDS LVN on 4/16/24 at 9:59 AM, observation of MDS LVN opening Resident #32's MDS in electronic health records. Surveyor showed MDS LVN physicians orders for a prescription for glasses, MDS LVN stated that is it not her job to follow up on physicians visits or appointments . She went on to state that as far as she knew, she did not know he needed glasses. She stated a possible negative outcome for resident not having the prescribed glasses would be a decline in health. In an interview on 04/16/24 at 10:25 AM, the CN stated a possible negative outcome for resident not having prescription glasses would be an increase in falls and not being able to participate in activities. In an observation and interview on 4/15/24 at 10:10 AM, revealed Resident #32 was ambulating in the hallway, not wearing glasses. He stated he loved to read and had not been able to for a long time. He stated that he talked with the SW about needing glasses last week and nothing had happened. In an interview on 04/16/24 at 10:30 AM, the ADON stated a possible negative outcome for not having prescription glasses for resident would be that they could fall or run into things . In an interview on 04/16/24 at 11:08 AM, the SW stated that Resident #32 has an appointment today at 2:00 PM to go and pick out prescription glasses. Record review of facility policy titled Resident Rights, dated 11/28/16 revealed the following: The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. .Respect and Dignity - The resident has a right to be treated with respect and dignity, including: . 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31882 Based on interview, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a weekfor the period reviewed from 11/1/23 to 4/13/24. The facility did not have an RN in the facility on 11/18/23 and 11/19/23, accounting for 2 days in the past months for the peroiod reviewed from 11/1/23 to 4/13/24. This deficient practice had the potential to affect residents in the facility by leaving staff without supervisory coverage for coordination of events such as emergency care. Findings include: During an interview on 4/14/24 at 1:30 pm, the HRC stated she called the corporate office and the HRD from Corporate pulled the timecard clock in and out information for RN coverage from November 2023 to present as requested. She stated the information was the most accurate information available. Record review of the facility's last 5 months of time sheetsfrom 11/1/23 to 4/13/24 for RN coverage revealed that the facility did not have an RN in the facility on 11/18/23 and 11/19/23. During an interview on 4/15/24 at 2:20 pm, the CRN stated of no RN coverage on 11/18/23 and 11/19/23, we just missed it. She stated the consequences of not having a nurse in the building would be that the nurse was a resource for the staff. During an interview on 4/15/24 at 2:50 pm, the ADM brought papers titled Time Clock Adjustment and stated RN H did work on 11/18/23 and 11/19/23. She stated RN H had accidentally marked the Telehealth instead of clocking in correctly. The ADM stated RN H had filled out a Time Clock Adjustment sheet for both days. During an interview on 4/16/24 at 8:38 am RN H got her calendar out and stated she did not work on 11/18/24 and 11/19/24. She stated she did not make an entry into telehealth for 1/18/23 or 11/19/23 or fill out a time clock adjustment paper for those two days. Record review of facility presented Time Clock Adjustment revealed the ADM gave 4 pieces of paper titled Time Clock Adjustment. All four of the Time Sheet Adjustment papers were warm from the copier and had white out tape over the IN Day and Out Day boxes on both the 11/18/23 and 11/19/23 sheets. Two of the Time Clock Adjustment sheets had Telehealth marked out and AM and PM were both circled for both dates. A policy for RN coverage was requested on 4/15/24 but was never received.

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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** 47854 Based on observation and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, administering, and documentation of all drugs and biologicals) to meet the needs of each resident for 4 out of 16 residents (Residents #2, #5, #32, #38,) whose medical records were reviewed for medication administration. -The facility administered insulin to Resident #5, Resident #32, and Resident #38 after it was expired. -RN B documented administration of an injectable medication under MA D's computer access, even though MA D did not give the medication. -RN G administered an injectable medication, and RN I documented medication administration under RN I's credentials. -The facility failed to establish a procedure to ensure Resident #2's medications were her prescribed medications before leaving the facility for weekend pass, which led to Resident #2 receiving another residents Depakote while out on pass. These deficient practices can affect residents that receive medications resulting in deterioration in their health, exacerbation of their disease process, and/or hospitalization . Inaccurate documentation can be misleading to care providers regarding what care, medications, and treatments residents have or have not received. Findings include: Resident #2 Record review of Resident #2's face sheet revealed a [AGE] year-old-female who was admitted to facility on 08/28/2023 with, but not limited to the following diagnosis: Major depressive disorder, recurrent, severe with psychotic symptoms, History of falling, Muscle weakness (Generalized), Unsteadiness on feet, difficulty in walking, not elsewhere classified, Essential (Primary) hypertension, Type 2 Diabetes, Mellitus without complications, Emphysema, unspecified, parkinsonism, Unspecified, mixed hyperlipidemia, Retention of urine unspecified, Obstructive and reflux uropathy, unspecified, Overactive bladder, gastroparesis, obstructive sleep apnea, (Adult) (Pedicatric), heart failure, unspecified, chronic obstructive pulmonary disease, unspecified, chronic kidney disease, state 3 Unspecified, Chronic pain syndrome, Polyneuropathy, generalized anxiety disorder, other seizures, Cognitive communication deficit, weakness. Record review of Resident #2's MDS, dated [DATE], revealed that Resident #2 had a Brief Interview for Mental Score (BIMS) of 15 and a functional capacity of extensive assistance with ADL's. (continued on next page)

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	675851	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Georgia Manor Nursing Home	2611 W 46th Ave Amarillo, TX 79110

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan which was reviewed on 03/08/2024, revealed that resident is a diabetic, is high risk for falls, requires antipsychotic medications, uncontrolled pain that is managed by pain management medication. Record Review of Resident #2's active physicians orders, dated 04/16/2024 that resident is not currently on Depakote, but does have an order for the following: Tylenol with Codeine #3 Oral Tablet 300-30 MG (Acetaminophen w/ Codeine) Give 1 tablet by mouth every 8 hours related to CHRONIC PAIN SYNDROME Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old female who was admitted to facility on 07/25/2018 with, but not limited to the following diagnosis: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified protein-calorie malnutrition, other specified abnormal findings of blood chemistry, anemia, unspecified, Type 2 diabetes mellitus without complications, vitamin D deficiency, unspecified, bipolar disorder, unspecified. Record review of Resident #5's MDS, dated [DATE], revealed that Resident #5 had a Brief Interview for Mental Score (BIMS) of 14 and a functional capacity of supervision and independence with ADL's. Record review of Resident #5's care plan which was reviewed on 03/28/2024, revealed that Resident was a diabetic. The care plan reflected, Intervention-Administer insulin as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #5's active physician's orders revealed Resident #5's insulin order as follow: Lantus Subcutaneous Solution 100 UNIT/ML (Insulin, Glargine) Inject 5 unit subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS Phone Active 03/07/2024 3/08/2024. Record review of Resident #5's MARs, dated for the Month of April, revealed that Lantus (insulin glargine) was administered at 07:00am on 04/11/2024, 04/12/2024, 04/13/2024, 04/14/2024. Record review of Resident #5's glucose check log, dated for 04/05/2024m revealed no adverse trends in Resident #5's blood glucose levels at time of discovery of expired medications. Resident #32 Record review of Resident #32's face sheet revealed that Resident #32 is a [AGE] year-old male who was admitted into the facility on [DATE] with the following, but not limited to, diagnoses: Type 2 diabetes mellitus without complications, unspecified protein-calorie malnutrition, hypertension, heart failure, acute kidney failure, unspecified, generalized anxiety disorder, major depressive disorder, recurrent severe without psychotic features. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #32's MDS, dated , 03/25/2024 revealed that Resident #32 had a Brief Interview for Mental Score (BIMS) score was not completed, however did indicate that Resident #32 was a diabetic and requires moderate to partial assist with ADL's. Record review of Resident #32's care plan, last review date of 03/08/2024 did not reflect that the Resident #32 is a diabetic and receives insulin. Record review of Resident #32's active physician's orders, dated 04/16/2024, revealed that Resident #32 will receive HumaLOG KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8; 401 - 800 = 10 Give 10 units and call MD. , subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS. Record review of Resident #32's February, March, and April MARs for 2024 revealed that Resident #32 received doses of Humalog (Lispro) after the insulin was opened/accessed and expired. Record review of Resident #32's glucose check logs, dated February, March, and April of 2024 revealed no adverse blood glucose trends in the time of being administered expired insulin. Resident #38 Record review of Resident #38's face sheet revealed a [AGE] year-old male resident who was admitted to the facility on [DATE]. Resident #38 had but not limited to the following diagnosis: Paranoid schizophrenia, displaced lateral mass fracture of first cervical vertebra, initial encounter for closed fracture, other psychoactive substance dependence, in remission chronic viral hepatitis C, essential (primary) hypertension, benign prostatic hyperplasia, without lower urinary tract, symptoms, shortness of breath, type 2 diabetes mellitus without complications. Unspecified protein-calorie malnutrition, mild cognitive impairment of uncertain or unknown etiology, chronic obstructive pulmonary disease, unspecified. Record review of Resident #38's MDS, dated [DATE] revealed that Resident #38 had a Brief Interview for Mental Score (BIMS) of 06 and a functional capability of needing partial/moderate assist to substantial/maximal assist depending on the ADL. Record review of Resident #38's care plan, reviewed on 03/05/2024, revealed that resident was a diabetic. Interventions are as follows: o Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 07/05/2023, Record review of Resident #38's active physician's orders revealed the following: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 12 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Phone Active 02/28/2024 02/28/2024. Record review of Resident #38's MARs for April 2024 revealed that Resident #38 received expired Lantus insulin every day except for 04/03/2024. There was not documentation on that day for receiving or refusing of insulin by Resident #38. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #38's glucose check logs revealed no adverse trends for Resident #38 while receiving expired insulin. Observation on 04/14/24 at 10:07 AM of the medication cart for Hall B & C revealed the following: -Humalog (Lispro) insulin For Resident #32 had an opening date of 02/16/2024. Medication was to be discarded after 10 days from open/access date, which would have been 02/26/2024. -Lantus insulin for Resident #38 had an opening date of 03/01/2024. Medication was to be discarded after 28 days from open/access date, which would have been 03/28/2024. Observation on 04/14/24 at 10:27 AM of medication cart A revealed the following: -Lantus Insulin pen for Resident #5 that had an opening date of 03/14/2024. Medication was to be discarded after 28 days which would have been on 04/11/2024. Interview on 04/14/24 10:31 AM with MA D was asked about the expired Lantus for Resident #5. MA D stated that she was not responsible for the insulin medications and never opened that drawer. Interview on 04/14/24 at 02:26 PM with RN B was asked if she administered expired insulin to Resident #32 this morning. RN B stated that she was not aware that the insulin was expired, and stated I didn't look at the expiration date. RN B was asked what a negative outcome would be for giving a resident an expired medication. RN B stated that the medication would not be effective. Interview on 04/14/24 at 02:52 PM with Resident #2 and family members. Resident #2's family member revealed that the facility had given her (family member) a medication of another resident when Resident #2 was picked up for a weekend pass for the recent holiday. Family member stated that she (family member) did not notice the medication error until she (family member) had administered the medication on the 2nd day of Resident #2 being at home. The family member stated that she called the facility and made them aware of the error and returned the medication the following Saturday. ADM and MD were notified, and family member was advised to monitor Resident #2. No adverse reactions were noted per family member, however Resident #2 stated that I got really sleepy, but nothing else really. Interview on 04/14/24 at 3:10 PM with CN was asked what the process or procedure was to release medications to family members or third parties. CN stated, I am not sure what they have been doing in the past, but there is not one. CN was asked what a negative outcome would be from not having a system to reconcile medications for residents would be. CN stated, Exactly what happened. Interview on 04/15/2024 at 08:55 AM RN G stated that she was about to give insulin to Resident #5. RN G was asked if medication was given yesterday (04/14/2024), and RN G stated that it had been given yesterday by the med aide. RN G proceeded to get medication ready for administration. Needle was placed on applicator, alcohol wipe, and proceeded to resident's room. Resident #5 was lying in bed and took her right arm out from under her blankets. RN G asked if the resident wanted the injection in her arm like always. Resident #5 stated yes. RN G proceeded to administer medication, investigator stopped RN G and asked to speak to her in the hallway. Investigator asked RN G to confirm the open date on the kwik-pen, she stated oh it is past 30 days. RN G was asked what a negative outcome would have been of giving the resident an expired insulin. RN G stated that possible report to the nursing board. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 04/15/24 at 09:11 AM revealed Resident #5's MAR, dated April 2024, indicated that MA D gave Resident #5 her insulin injection. Interview on 04/15/24 at 10:06 AM with Resident #5. Resident #5 was asked if her insulin injections were given by MA D at any time or if ever. Resident #5 stated that the med aide can't give it, only the nurses can give it. Interview on 04/15/24 at 10:10 AM with CN stated that MA's never give injections, CN stated that RN B stated to her that she didn't know that she documented the injection under the MA D's log in and will come in and make that correction today. Interview on 04/15/24 at 10:14 AM with MA D stated that she does not give injections to residents ever. MA D stated that RN B got flustered yesterday and documented the insulin injection yesterday (04/14/202) under her credentials. Record Review on 04/15/24 at 02:36 PM of Resident #5's MAR, dated April 2024, revealed that the medication documentation error had not been corrected. Record Review on 04/16/24 at 08:37 AM of Resident #5's MAR, dated April 2024, revealed that the medication documentation error had not been corrected. During this review of record the MAR revealed that medication was given this morning. Interview on 04/16/24 at 08:40 AM with RN G and RN I were asked who administered insulin to Resident #5 this morning (04/16/2024). RN G stated that she administered medication, but RN I documented medication on the MAR. When asked why it was done that way, RN I stated I was standing in the doorway and saw her give it, and then I just signed off on it. I took over the medication cart. She (RN G) is just doing blood pressures. RN G stated, I came in at 6am and she (RN I) took over the cart, I had already pulled the medication and gave it to [Resident #5]. RN G was asked why she didn't document for the medication, RN I stated, I just signed off for it, I saw her give it and I am giving the meds. Interview 04/16/24 at 03:22 PM with CN stated that the negative outcome of giving residents expired medications was that the medication will lose its effectiveness over time. CN was asked what a negative outcome of nurses documenting under another staff's credentials would be, CN stated that it is false documentation. Record review of facility provided policy titled, Medication Administration Procedures, revised 10/25/2017, revealed the following: 2. Medications are to be poured, administered and charted by the same licensed person. 5. All nurses administering medication must sign and initial the designate area of each resident's medication/treatment administration record or resident specific master signature log for identification of all initials used in charting. .20. The 10 rights of medication should aways be adhered to . .7. Right documentation . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility provided policy titled, Discharge Planning Process policy, revised 11/28/16, revealed the following: Discharge summary must include: . .B). Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). Record review of facility provided policy titled, Documentation , revised May 2015, revealed the following: Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. Record review of facility provided policy titled, Medication labeling, dated 2003, revealed the following: PROCEDURE Each prescription medication label includes: .4. Expiration date of all dated drugs.

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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** 47854 Based on observation, the interview and record review, the facility failed to ensure residents were free of any significant medication errors for one of 1 (Resident #5) residents reviewed for medication administration. -RN was attempting to administer Resident #5's expired insulin. This failure could place residents who receive insulin medications at an increased risk for complications such as increased blood glucose levels, change in cognition, and an exacerbation of symptoms and disease process. Findings include: Record review of Resident #5's face sheet revealed Resident #5 is a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5's current diagnosis was as follow, but not limited to type 2 diabetes mellitus without complications, other specified abnormal findings of blood chemistry, unspecified protein-calorie malnutrition, depression, unspecified, anxiety disorder, unspecified. Record review of Resident #5's current MDS, dated [DATE] revealed that Resident has a BIMS of 14. Active diagnoses indicates that Resident #5 had Diabetes Mellitus and requires supervision with toileting hygiene, lower body dressing, and putting on/taking off footwear. All other ADLs Resident #5 is setup or independent. Record review of Resident #5's care plan, was reviewed on [DATE], revealed, in part: Focus [Resident #5] has diabetes, date initiated [DATE]. Intervention .Administer insulin as ordered by doctor. Monitor/document for side effects and effectiveness. Date initiated [DATE]. Record review of Resident #5's physician orders, dated [DATE], Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 5 unit subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9), Phone Active [DATE] [DATE] Record review of Resident #5's MARs, dated [DATE], revealed, in part, that Resident #5 had received expired insulin on [DATE] at 0700 AM, [DATE] at 0700 AM, [DATE] at 0700 AM, and [DATE] at 0700 AM. (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 Resident #5's blood glucose logs, revealed a blood glucose check on [DATE] of 145. 0mg/dl, and [DATE] of 144.0mg/dl. Observation/Interview on [DATE] at 08:50 AM revealed a medication administration for Resident #5's insulin, open date on medication kwik-pen revealed an open date of [DATE], medication should have been discarded on [DATE], in the medication cart. RN G stated that she was about to give medication and proceeded to get medication ready for administration. Needle was placed on applicator, alcohol wipe, and RN G proceeded to Resident #5's room. Resident #5 was lying in bed and took her right arm out from under her blankets. RN G asked if Resident #5 wanted the injection in her arm like always. Resident #5 stated yes, RN G proceeded to administer medication, investigator stopped RN G and asked to speak to her in the hallway. RN G was asked to confirm the open date on the kwik-pen, RN G stated, Oh it is past 30 days. RN G was asked what a negative outcome would have been of giving the resident an expired insulin. RN G stated that possible report to the nursing board. Interview on [DATE] 03:22 PM CN was asked what a negative outcome of administering medication to a resident. CN stated that the medication can lose its effectiveness and not work for the resident. Record review of facility provided policy titled, Medication Administration procedures revised on [DATE], revealed the following: .15. Medication errors and adverse drug reactions are immediately reported to the resident's Physician. In addition, the Director of nurses and/or designee should be notified of any medication errors. Any medication error will require a medication error report that includes the error and actions to prevent reoccurrence. Record review of facility provided policy titled, Medication labeling, dated 2003, revealed the following: PROCEDURE Each prescription medication label includes: .4. Expiration date of all dated drugs.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47854 Based on observation, interview, and record review, it was determined the facility failed to ensure drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable on 2 of 2 medication carts reviewed for medication storage. -70 medications were found left loose in the B & C Hall medication cart and 4 medications were found left loose in the A Hall medication cart. -2 insulin medications were found in Hall B & C medication cart with no date of when they were opened. The facility's failure to ensure drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable could place 40 residents receiving medication at risk for drug diversion, drug overdose, and accidental or intentional administration to the wrong resident. Findings include: Observation on 04/14/24 at 10:07 AM revealed 65 unidentified whole pills and 5 unidentified 1/2 pills in the medication cart for the B & C hall drawers. RN B was not able to identify any of the medications that were discovered in the cart. Medications that were discovered were placed in the Drug disposal in a bottle for destruction by RN B. Interview on 04/14/24 at 10:17 AM with RN B stated that the negative outcome for all of the medications being loose in the bottom of the medication drawers was the residents are missing their medications. Observation on 04/14/24 at 10:27 AM revealed 3 unidentified whole pills and 1 unidentified 1/2 pill in medication cart for A hall drawers. Upon observation of the Insulin drawer, it was discovered that there were 2 insulins with no open/access date written on the medication. Interview on 04/14/24 10:36 AM MA D was asked what she is to do with loose medications that are found in medication drawers, MA D stated to throw them in the trash. MA D asked RN B what she was supposed to do with loose pills found in the medication carts. RN B stated to place medications in the Drug disposal in a bottle. When MA D was asked what a negative outcome of having lose pills in medication cart was, MA D responded with I don't know. Observation on 04/15/24 11:19 AM revealed LVN F leaving medication cart for Hall B unattended and unlocked. There were 4 unidentified residents in the hallway close to the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/15/24 11:22 AM revealed LVN F leaving the medication cart for Hall B unattended and unlocked, there were 2 unidentified residents in the hallway close to the medication cart. Interview on 04/15/24 11:29 AM LVN F was asked why the medication cart was left unattended and unlocked. LVN F didn't answer the question. LVN F was asked what a negative outcome for leaving the medication cart unlocked and unattended, LVN F stated, someone could open it. Interview on 04/16/24 03:35 PM CN was asked what a negative outcome would be for medication carts to be left unlocked and unattended. CN stated that residents could get in and take random medications. Record review of facility provided policy titled, Medication labeling, dated 2003, revealed the following: PROCEDURE Each prescription medication label includes: .4. Expiration date of all dated drugs. Record review of facility provided policy titled, Medication Carts, dated 2003, revealed the following: 1. The medication cart shall be maintained by the facility. 2. The carts are to be locked when not in use or under the direct supervision of the designated nurse. .4. Carts must be secured.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31882 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen observed for food storage, preparation, and distribution. A. CK A did not perform hand hygiene appropriately when preparing pureed foods. This failure could place residents who ate food served by the kitchen at risk of food-borne illness from cross-contamination. Findings included: During an observation and interview on 4/14/24 at 11:00 AM, CK A was observed preparing the mechanical soft and pureed foods. CK A changed her gloves then touched various kitchen surfaces including the prep table and the puree machine. CK A removed the lid of the puree machine and put a chicken patty into the machine with her gloved hands. CK A did not change her gloves or wash her hands. CK A then walked over to another part of the kitchen and shook the handle of the fryer basket. CK A walked back to the puree machine reached into the machine, picked up a chicken patty out of the puree machine and tore the chicken up with her gloved hands.CK A replaced the lid to the puree machine and resumed the making of the mechanical soft meat. Cook A stated she is not supposed to touch the food with her hands and is supposed to change gloves between tasks. She stated this could cause cross contamination. During an observation and interview on 4/14/24 at 11:10 AM, with the DM, CK A was observed preparing the pureed foods. CK A changed her gloves but did not wash her hands. CK A then touched various kitchen surfaces including the prep table and the puree machine. CK A touched the basket of the fryer and returned to the chicken she was pureeing. CK A removed the lid of the puree machine and stirred the pureed chicken with the spatula. Then CK A dropped a small amount of pureed chicken onto the palm of her ungloved hand and licked the chicken off her hand. CK A washed her hand off with water only and picked up the tongs and the fry basket and began using the tongs to remove the chicken from the fry basket to the serving pan. CK A then put gloves on and did not wash her hands before putting the loves on. This surveyor asked the DM if she saw the CK A put gloves on without washing her hands. The DM stated she was aware CK A did not wash her hands between tasks. The DM stated CK A should have washed her hands and changed her gloves when switching tasks. The DM stated not changing gloves and washing hands could cause food borne illness. The DM stated she traied the staff in hand washing techniques. Record review of facility policy titled, Food Safety, revealed, in part: Gloves must be worn for preparation and service of foods where direct hand to food contact is unavoidable. Record review of facility policy titled, Infection Control, revealed, in part: Careful handwashing by personnel will be done between handling of cooked and uncooked foods. Between handling of dirty dishes, boxes, equipment and handling of clean food or utensils.

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	675851	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Georgia Manor Nursing Home	2611 W 46th Ave Amarillo, TX 79110

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on interview and record review, the facility failed to maintain complete, accurate, readily accessible, and systemically organized records for 1 (Resident #5) of 16 residents reviewed for medical records. -RN B documented administration of injectable medication under MA D's computer access. -RN G administered injectable medication, RN I documented medication administration under RN I's credentials. This failure could place residents at risk of not receiving appropriate care through inaccurate documentation which can be misleading to care providers regarding what care, medications, and treatments residents have or have not received. Finding include: Record review on 04/15/24 at 09:11 AM revealed Resident #5's MAR indicated that MA D gave Resident #5 her insulin injection on 04/14/2024 at 0700 AM. Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year-old female who was admitted to facility on 07/25/2018 with, but not limited to the following diagnosis: UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY, UNSPECIFIED PROTEIN-CALORIE MALNUTRITION, OTHER SPECIFIED ABNORMAL FINDINGS OF BLOOD CHEMISTRY, ANEMIA, UNSPECIFIED, TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, VITAMIN D DEFICIENCY, UNSPECIFIED, BIPOLAR DISORDER, UNSPECIFIED Record review of Resident #5's MDS, dated [DATE], revealed that Resident #5 had a BIMS of 14 and a functional capacity of supervision and independence with ADL's. Record review of Resident #5's care plan which was reviewed on 03/28/2024, revealed that Resident is a diabetic. Intervention-Administer insulin as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #5's active physician's orders revealed Resident #5's insulin order as follow: Lantus Subcutaneous Solution 100 UNIT/ML (Insulin, Glargine) Inject 5 unit subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS Phone Active 03/07/2024 3/08/2024. Record review of Resident #5's MARs revealed that Lantus (insulin glargine) was administered at 07:00am on 04/11/2024, 04/12/2024, 04/13/2024, 04/14/2024. Expiration date of this medication was 04/11/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/15/24 at 10:06 AM with Resident #5. Resident #5 was asked if her insulin injections were given by MA D at any time or if ever. Resident #5 stated that the Med aide can't give it, only the nurses can give it. Interview on 04/15/24 at 10:10 AM with CN stated that MA's never give injections, CN stated that RN B stated to her that she didn't know that she documented the injection under the MA D's log in and will come in and make that correction today on her break from her other job today. Interview on 04/15/24 at 10:14 AM with MA D and she stated that she does not give injections to residents ever. MA D stated that RN B got flustered yesterday and documented the insulin injection yesterday under her credentials. Record Review on 04/15/24 at 02:36 PM of Resident #5's MAR revealed that the medication documentation error had not been corrected. Record Review on 04/16/24 at 08:37 AM of Resident #5's MAR Revealed that the medication documentation error had not been corrected. Interview on 04/16/24 at 08:40 AM with RN G and RN I were asked who administered insulin to Resident #5 on 04/16/2024 at 0700 AM. RN G stated that she administered medication, but RN I documented medication on the MAR. When asked why this was done this way, RN I stated I was standing in the doorway and saw her give it, and then I just signed off on it. I took over the medication cart. She (RN G) is just doing blood pressures. RN G stated, I came in at 6am and she (RN I) took over the cart, I had already pulled the medication and gave it to [Resident #5]. RN G was asked why she didn't document for the medication, RN I stated, I just signed off for it, I saw her give it and I am giving the meds. Interview 04/16/24 at 03:22 PM with CN stated that the negative outcome of giving residents expired medications is that the medication will lose its effectiveness over time. CN was asked what a negative outcome of nurses documenting under another staff's credentials would be, CN stated that it is false documentation. Record review of facility provided policy titled, Medication Administration Procedures, revised 10/25/2017, revealed the following: 2. Medications are to be poured, administered and charted by the same licensed person. 5. All nurses administering medication must sign and initial the designate area of each resident's medication/treatment administration record or resident specific master signature log for identification of all initials used in charting. .20. The 10 rights of medication should aways be adhered to . .7. Right documentation .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. -RN B failed to perform hand hygiene (HH) before donning gloves to administer an inhalation medication. -RN B failed to perform HH and don gloves before performing a glucose check. -LVN F failed to perform HH before or after administering an injectable medication. -LVN F failed to don or doff gloves before or after administering an injectable medication. -CNA C failed to perform HH or glove change after performing incontinent care on a resident and starting with the clean aspect of incontinent care. -CNA E failed to perform HH or glove change during incontinent care of resident. -CNA E failed to perform incontinent care on a resident in an aseptic manner. -CNA C failed to perform HH before donning new gloves after being contaminated during incontinent care of resident. -CNA E failed to perform HH or glove change after removing dirty brief and then proceeding to touch clean items of resident. -RN G failed to perform HH before administering an injectable medication -RN G failed to perform donning and doffing of gloves before the administration of an injectable medication. These deficient practices have the potential to affect all residents in the facility by exposing them to care that could lead to the spread of viral infections, secondary infections, communicable diseases. Findings include: Observation on [DATE] at 08:43 AM revealed RN B administering an inhalation medication to a resident. No hand hygiene was performed by RN B before donning gloves to administer this medication to the resident. Observation on [DATE] at 11:17 AM revealed that RN B performing a blood glucose check for resident, no hand hygiene was performed by RN B before donning gloves to perform glucose check. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 11:32 AM with RN B revealed RN B stating that the negative outcome for not performing hand hygiene and donning gloves before performing resident cares and treatments is infection control. Observation on [DATE] at 09:02 AM revealed incontinent care performed by CNA C and MA D with resident. HH was performed before incontinent care began by both CNA C and MA D. HH was not performed when a glove change took place after cleaning resident and rolling dirty brief under the resident who was turned to her right side away from CNA C. HH was not performed before donning new gloves to continue with peri-care by CNA C. A clean brief was placed under the resident with no HH or changing of gloves. Resident was then rolled to her left side so that MA D could remove the dirty brief from underneath resident and pulled the clean brief out from under the resident. There was no HH or glove change before CNA C had the resident roll back onto her back. CNA C proceeded to recover resident after incontinent care was complete with resident's bed linens with the same gloves, she discarded the dirty brief with. HH was not performed by CNA C after incontinent care was concluded and she left the room. Interview on [DATE] at 09:16 AM with CNA C, stated that she didn't know why she didn't perform HH and that it could lead to the spread of infection. Observation/Interview on [DATE] at 08:50 AM revealed a medication administration for Resident #5's insulin, open date on medication kwik-pen revealed an open date of [DATE], medication should have been discarded on [DATE], in the medication cart. RN G stated that she was about to give medication and proceeded to get medication ready for administration. Needle was placed on applicator, alcohol wipe, and RN G proceeded to Resident #5's room. Resident #5 was lying in bed and took her right arm out from under her blankets. RN G asked if Resident #5 wanted the injection in her arm like always. Resident #5 stated yes, RN G proceeded to administer medication, investigator stopped RN G and asked to speak to her in the hallway. RN G was asked to confirm the open date on the kwik-pen, RN G stated, Oh it is past 30 days. RN G was asked what a negative outcome would have been of giving the resident an expired insulin. RN G stated that possible report to the nursing board. Interview on [DATE] at 8:57 AM with RN G stated that a negative outcome would be for not performing HH or donning gloves to administer an injectable medication would be. RN G stated, I didn't even think, it could lead to a possible needle stick, exposure to residents' blood, and the spread of infection. Observation on [DATE] at 10:27 AM revealed incontinent care performed by CNA C and CNA E with resident. CNA E performed HH at the beginning of incontinent care and donned gloves. During removing dirty brief on resident and starting incontinent care on resident there was no HH or glove change by CNA E. Once resident was turned away for cleaning to be done to the backside of resident. CNA E wiped resident from the top of buttocks to the front of the resident, in a back to front motion. CNA E performed this action 3 times, after cleaning resident, gloves were changed but no HH was performed. Clean brief was placed under resident and then resident was rolled to opposite side. CNA C was then removing the dirty brief from underneath the resident and pulling clean brief out from under the resident with the same gloves she just used to handle the soiled brief. CNA C handed the soiled brief to CNA E who threw the soiled brief in the trash. CNA E and CNA C both touched the dirty brief and the clean brief without HH or glove change. Gloves were changed, but no HH was performed before the cleaning of the room and returning resident to a comfortable position and recovering resident with bed linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 10:39 AM with CNA E was asked why she cleaned resident from back to front and she stated, I didn't think I did. CNA was asked about a negative outcome of cleaning a resident from a dirty to clean motion, and not performing HH and glove changes. CNA E stated that not performing HH, glove changes and improper cleaning of a resident could lead to the spread of infection. Observation on [DATE] at 10:56 AM revealed incontinent care performed by CNA C and MA D with resident. Resident was sitting on toilet and was able to perform cleaning of the front peri area. MA D removed soiled brief and pants of the resident. MA D did not perform a glove change or HH and then placed a clean brief and clean pants on resident while she was sitting on the toilet. MA D then performed peri care of the residents back side with disposable wipes. MA D then assisted resident with the pulling up of her brief and pants with the same gloves she just wiped feces off of resident's buttocks. MA D then touched residents w/c and assisted resident to sit in w/c with the same gloves on that she performed peri-care of resident's buttocks. CNA C then collected all dirty linens and brief from resident's room took linen to dirty linen closet in hallway and never performed HH after removing gloves. Interview on [DATE] at 11:06 AM with MA D and CNA C were asked what a negative outcome would be for not performing HH and glove changes. MA D stated that it would spread germs and I just know better. CNA C stated, I don't know why I didn't, and we just talked about it. Observation on [DATE] at 11:19 AM revealed LVN F was preparing an injectable medication for an unidentified resident. LVN F did not perform hand hygiene or don gloves before going into the room to administer injectable medication to resident. LVN F did not perform hand hygiene after the medication administration either. Interview on [DATE] at 11:27 AM LVN F stated that a negative outcome for not performing HH and donning gloves would be it could be the blood. Record review of facility provided policy titled SUBCUTANEOUS INJECTION ADMINISTRATION dated 2003 revealed the following: 1. Check expiration date of medication and the most resent injection site. 2. Wash your hands and put on clean disposable gloves. 13. Remove and dispose of gloves and wash hands. Record review of facility provided policy titled Perineal care, dated [DATE], revealed the following: 10. Perform hand hygiene 11. Don gloves and all other PPE per standard precautions i. Choose your PPE by considering the type of exposure, the durability and appropriateness for the task . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.17. Gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area to avoid contaminating the urethral area - CLEAN to DIRTY! . .21. Gently perform care to the buttocks and anal area, working from front ho back without contaminating the perineal area . .24. Doff gloves and PPE 25. Perform hand hygiene . .Always perform hand hygiene before and after glove use Record review of facility provided policy titled Hand Washing, dated 2012 revealed no mention of when to perform hand hygiene. Policy only mentioned on how to perform hand washing.