STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675909	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harker Heights Nursing & Rehabilitation	415 Indian Oaks Dr Harker Heights, TX 76548

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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 42949 Based on observation, interviews and record reviews, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered by the state for 2 of 2 Activity Director (AD) reviewed for qualified professionals, in that: The facility failed to have a qualified AD to serve as the director of the activities program. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident. The findings included: Interview on 12/07/24 at 9:54 am the AD revealed she was just hired as an AD; she was previously a CNA. She stated she was enrolled in the AD certification and training program, but she was not certified. Interview on 12/08/24 at 10:57 am with the ADM revealed the facility currently did not have ADs who were certified qualified therapeutic recreation specialists or certified activity professionals. The ADM revealed the facility had an AD for the secured memory care unit, who was not certified, and an AD for the remainder of the facility residents, who was not certified . The ADM revealed the negative affect of not having certified ADs would be there were not as many activity opportunities for the residents. Review of facility Activities Director job description reflected Current certification as a Certified Activities Director required. Review of facility policy, Activities Program, dated January 2023 reflected the activities program is directed by a qualified professional who is a qualified therapeutic recreation specialized and is licensed or registered, if applicable, by the state, is eligible for certification as a therapeutic recreation specialist or as an activities profession by a recognized accrediting body on or after October 1, 1990. A recognized accrediting body is an organization or association recognized as such by certified therapeutic recreation specialists, certified activity professional, or registered occupational therapist, has completed a training course approved by the state.

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

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for one (Resident #1) of five residents reviewed for pressure injuries. The facility failed to instate wound treatment orders for Resident #1 after she was admitted from the hospital after a hip fracture requiring surgery on 10/18/24 until 10/22/24. When she was admitted there was shearing to her sacrum and after not receiving treatment the wound was a stage III. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 12/03/24 at 5:19 PM and an IJ template was given. While the IJ was removed on 12/05/24 at 5:29 PM, the facility remained out of compliance at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including stroke, type II diabetes, end-stage renal disease, and need for assistance with personal care after a hip fracture requiring surgery. Review of Resident #1's admission MDS assessment, dated 10/22/24, reflected a BIMS score of 5, indicating a severe cognitive impairment. Section M (Skin Conditions) reflected she had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device and was at risk of developing pressure ulcers/injuries. Review of Resident #1's admission care plan, dated 10/19/24, reflected she was at risk for skin impairment due to frail and fragile skin and decreased mobility with an intervention of handling fragile skin with caution and reporting to a nurse if any skin concerns were to arise. Review of Resident #1's discharge hospital paperwork, dated 10/18/24 reflected a skin assessment - L hip - ORIF, L fistula, R dialysis cath, R knee scab, and redness to sacrum. Review of Resident #1's Admission/Readmission Assessment, dated 10/19/24 and completed by LVN A , reflected an open/significant skin issue with an open area to buttock and shearing, redness to right knee, scab on knee. Review of Resident #1's Skin and Wound Evaluation, dated 10/23/24 and completed by the TN, reflected a stage III pressure injury (full-thickness skin loss) to her left gluteus measuring 9.0 cm x 5.9 cm. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of the picture of Resident #1's wound, taken on 10/23/24 by the TN, revealed a large wound with multiple pink areas where the top layer of skin was missing, a yellow area in the center reaching into the tissue under the skin layers, and some black scab-like tissue covering part of the wound. Review of Resident #1's physician order, dated 10/23/24, reflected TX - left buttocks, cleanse w/wc, pat dry, apply Santyl to areas of slough, apply triad to macerated skin, and cover with foam dressing one time a day every Mon, Wed, Fri for wound care and as needed for soiled or dislodged dressing. Review of Resident #1's hospital records, dated 10/24/24, reflected the following: .presented to ED on 10/24/24 presentation concerning for sepsis with subsequent blood cultures showing Gram-positive organisms . However [Resident #1] is unable to have oral intake because of weakness at this point as well as change in mental status and we will reassess. During an interview on 12/03/24 at 10:54 AM, the WCN stated he was at the facility once a week to do wound assessment rounds with the TN. He stated if a resident was admitted with wounds, the TN wound text/call to inform him and the next time he was at the facility he would evaluate wound and write orders. He stated until he assessed the wound, there should be their standing wound treatments put into place. He stated he expected to be notified if a resident was admitted with a wound or developed one at the facility. He stated he did not remember being notified of Resident #1's wound or assessing her. During an interview on 12/03/24 at 12:04 PM, the NP stated if a resident was admitted with a wound or skin issues, the TN needed to assess right away. She stated they did have a few standing orders for skin tears and excoriation but then the TN/WCN would need to assess to see if there was anything else that needed to be implemented. She stated as soon as a skin issue was identified, interventions needed to be put in place immediately. During a telephone interview on 12/03/24 at 1:23 PM, the MD stated typically, if a resident had any skin integrity issues, it would cause nurses to call attention to that. He stated TN would then assess and would contact the WCN if needed. He stated his expectations were that treatment orders be put in place immediately and the WCN to assess the skin issues weekly upon his rounds. During an interview on 12/03/24 at 4:58 PM, the IDON stated all nurses were responsible for wound care orders and to initiate standing treatment orders until assessed by the WCN. She stated this was important to prevent deterioration of a wound. She stated wound care was part of a resident's plan of care and should be addressed upon admission. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/04/24 at 12:43 PM, the TN stated she could not remember how she was informed of Resident #1's wound - if the nurse told her directly (on 10/22/24) or if she was running report. She stated how it usually went was a nurse would tell her about a resident's skin integrity issues or she would run a report based on the nurses' skin assess or admission assessment. She stated she remembered Resident #1 and provided wound care on 10/22/24. She stated Resident #1 was admitted on a Friday after she had had already left for the day and the admitting nurse (LVN A) did not do her follow-through. She stated LVN A should have assessed her skin and put standing wound care orders in place. She stated after the skin assessments, nurses did not feel obligated to take action to care for the resident. She stated she had problems with nurses seeing skin issues on residents and then not following up with resident care. She stated she had conducted multiple in-services about that. She stated the problem with the incident with Resident #1 was the lack of follow-through because LVN A did not obtain orders for wound care. She stated she marked, documented, and described the wound and then did not do anything about it. On 12/04/24 and 12/05/24, multiple attempts were made to contact LVN A. A returned phone call was not received prior to exiting. Review of in-services entitled Skin Assessment and Wound Care at Time of Admission, dated 06/12/24 and 11/05/24 and conducted by the TN, reflected nursing staff were educated on the following: New admissions who arrived with skin impairments have to have treatment orders initiated at time of admissions this cannot be delayed and is the responsibility of the admitting charge nurse. Charge nurses taking new admissions are required to complete the (EMR) admission assessment this requires a head-to-toe assessment to enter accurate information. During this time charge nurses should document any skin impairments in the admission assessment. If the discharge orders the pt arrives with does not include treatment orders, the admitting nurse is responsible for entering the appropriate standing wound care order. A list of standing wound care orders can be found in 24hr nursing binder, pink wound care nurse binder, and in the physician's communication binder. Review of an undated document entitled Standing Wound Care Treatment Orders reflected standing orders for the following: reddened rashes to sacral/buttocks MASD (moisture associated skin damage), skin tears, nonruptured [sic] blisters, DTI and ruptured blisters, and abrasions and superficial trauma injuries. Review of the facility's Skin and Wound Prevention Management Policy, revised January 2023, reflected the following: An individual's skin is the largest organ of the body . Each resident will receive the care and services necessary to retain or regain optimal skin integrity. . Guideline: . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Abuse & Neglect and Medication Administration, Accurate transcribing of physician orders and ensuring that any skin issue has an appropriate wound care / treatment order in place and that the wound care is being provided as prescribed. Date Completed: 12/4/2024. Director of Clinical Operations / Assistant Director of Nursing completed 100% of skin sweep was conducted on all residents who currently reside in the community was completed. No newly identified pressure areas. Date Completed on 12/4/2024. Director of Clinical Operations / Assistant Director of Nursing will conduct 100% audit of all current in-patient new admissions / re-admissions wound care/treatment orders reconciliation to validate accuracy of the admission / re-admission orders transcribed into the electronic medical record. Outcome: No negative outcome noted Date Initiated: 12/3/2024. Date Completed: 12/4/2024. Director of Clinical Operations / Administrator removed from schedule the agency nurse who was responsible for the admission in question, nurse was permanently removed and reported to the staffing agency as no longer allowed to work at facility. Date completed: 12/3/2024. Director of Clinical Operations / Assistant Director of Nursing will ensure all licensed nursing staff will be re-educated to include any licensed nurse on leave/agency/PRN staff. All licensed nurses will be in-serviced prior to assuming next shift. Director of Clinical Operations/Administrator will ensure administrative nursing staff is available to provide in-service/education prior the licensed nurses working. Risk: All admissions/readmissions with a potential for skin breakdown are at risk for being affected by the deficient practice. Systemic Response: Director of Clinical Operations / Assistant Director of Nursing initiated in-service training for licensed nurses regarding the process for: o Licensed nurse should conduct appropriate medication/treatment reconciliation of the hospital discharge orders and should confirm all hospital discharge orders with the accepting attending physician upon admission. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Licensed nurse should conduct a complete skin assessment and validate that any identified skin issue has an appropriate treatment order in place. o Post medication/treatment orders reconciliation, the licensed nurse should validate that the appropriate wound care / treatment order is in place as per the hospital discharge orders or an alternate wound care/treatment order has been provided upon admission and validate that the wound care / treatment order is accurately transcribed into the electronic health record physician orders once confirmed by the assigned medical provider and that the prescribed wound care has been administered as ordered . o Clinical leadership licensed nurse should review all new admission/re-admission wound care / treatment orders, validate that the wound care / treatment orders have been correctly transcribed into the electronic health record (physician orders) in comparison to the hospital discharge order to validate the accuracy and proper transcription of as well as to ensure that the appropriate wound care / treatment order is being administered as prescribed. Should any discrepancies be identified, the licensed nurse should immediately report the discrepancy to the medical provider and clarify with the attending physician/medical provider any new orders and will complete a medication error report as indicated. o Abuse & Neglect and Medication Administration, Accurate transcribing of physician orders and ensuring that any skin issue has an appropriate wound care / treatment order in place and that the wound care is being provided as prescribed. Date commenced: 12/3/2024. Date completed: 12/4/24. Licensed nurses will complete a competency test in order to validate competency regarding the process for medication/treatment orders reconciliation, confirming that the resident has appropriate wound care orders upon admission/re-admission and the process for transcribing wound care orders into the electronic health record in order to validate competency of the facility's expected practices. Date Initiated: 12/4/2024 and ongoing. Director of Clinical Operations / Assistant Director of Nursing will conduct 100% audit of all current in-patient new admissions / re-admissions wound care/treatment orders reconciliation to validate accuracy of the admission / re-admission orders transcribed into the electronic medical record. Outcome: No negative outcome noted Date Initiated: 12/3/2024. Date Completed: 12/4/2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Clinical Operations / Assistant Director of Nursing will ensure all licensed nursing staff will be re-educated to include any licensed nurse on leave/agency/PRN staff. All licensed nurses will be in-serviced prior to assuming next shift. Director of Clinical Operations/Administrator will ensure administrative nursing staff is available to provide in-service/education prior the licensed nurses working. Monitoring: Director of Clinical Operations /Assistant Director of Nursing will conduct random weekly (1-7 days per week for 2 weeks) audit of new admission / re-admission physician orders to include but not limited to validate the accuracy of the wound care / treatment orders reconciliation and accurate transcription of the wound care orders provided by the physician/medical provider upon admission as well as to validate that the wound care orders were properly confirmed and accurately transcribed within the E.H.R. The Director of Clinical Operations / Assistant Director of Nursing will maintain a monitoring log of the audits conducted identifying compliance throughout the monitoring period. Director of Nursing/Assistant Director of Nursing will conduct daily reviews during clinical start-up meeting (1-7days per week for 2 weeks) review of new / re-admission orders, admission assessment, progress notes, and the 24-hour report to ensure that appropriate interventions and/or all needed follow up has been assigned. The Director of Clinical Operations / Assistant Director of Nursing will maintain a monitoring log to validate that the daily (1-7 days per week) monitoring has taken place and the outcome of the review, identifying any related compliance issue. This monitoring plan will remain in place for the next 2-3 months to ensure compliance or to identify additional training needs. All findings will be reported to the QAPI committee during monthly meeting for the next 2-3 months. Administrator, Director of Clinical Operations, and the Medical Director conducted an Ad Hoc QAPI meeting to review the identified alleged deficient practice and plan of removal (corrective action plan) implemented. Date of completion: 12/4/2024. The Surveyor monitored the POR on 12/05/24 as followed: During interviews on 12/05/24 from 2:03 PM - 4:46 PM, six LVNs and eight CNAs from multiple shifts stated they were in-serviced on multiple topics prior to their shifts. They all stated they were in-serviced by the DCO on abuse and neglect and the ADM was their Abuse and Neglect Coordinator. They gave examples of abuse such as physical, sexual, financial, or verbal. The CNAs all stated if they noticed any skin impairments to residents' skin during personal care or showers, they would report it to the nurse immediately. They all stated it was important for their shower sheets to reflect any skin impairments such as a rash, redness, lacerations, or bruising. The LVNs all stated the importance of detailed skin assessments was to reflect exactly what was going on with the residents' skin. They stated if a resident was admitted from the hospital, they would initiate treatment immediately and not wait for the TN. They all stated there were standing wound care orders, but they would also contact the NP and describe the wound to see if they wanted to add anything additional to the order(s). They all stated they would ensure they notified the TN so she could follow up and assess the resident. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Ad Hoc QAPI meeting Agenda, dated 12/03/24, reflected the ADM, the DNS, key nursing leadership, and the MD were in attendance. Review of an audit conducted by the DCO and ADON, on 12/04/24, reflected a 100% skin sweep was conducted on all residents in the facility with no findings of newly identified pressure areas. Review of an audit conducted by the DCO and ADON, from 12/03/24 - 12/04/24, reflected 100% accuracy of all residents' wound care treatment orders. Review of an in-service entitled Abuse and Neglect, from 12/03/24 - 12/04/24 and conducted by the DCO (IDON), reflected nursing staff from all shifts were educated on the facility's Abuse and Neglect policy. Review of an in-serviced entitled Wound Care/Treatment Orders, from 12/03/24 - 12/04/24 and conducted by the DCO, reflected nursing staff from all shifts were educated on ensuring that all skin issues had appropriate wound/treatment orders in place and that wound care was being provided as prescribed. Review of Charge Nurse Admit/Readmit Competency Checks, from 12/03/24 - 12/04/24, reflected all nurses passed the competency checks regarding wound treatment orders. Review of an e-mail sent by the ADM, dated 12/05/24 at 4:11 PM, reflected at that time 81% of their CNAs and 90% of their nurses had been in-serviced and the rest would be in-serviced before working the floor. The ADM and DON were notified on 12/05/24 at 5:29 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for one (Resident #1) of four residents reviewed for medication errors. The facility failed to: -Ensure Resident #1's order for insulin was instated upon admission from the hospital on 10/18/24. -Ensure Resident #1's medication orders were accurate as she was being administered two anti-seizure medications in which she did not have a diagnosis for which resulted in a sudden change in consciousness/responsiveness and she had to be sent to the hospital. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 12/03/24 at 5:19 PM and an IJ template was given. While the IJ was removed on 12/05/24 at 5:29 PM, the facility remained out of compliance at a level of no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, worsening or exacerbation of chronic medical conditions, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including stroke, type II diabetes, and end-stage renal disease. Review of Resident #1's admission MDS assessment, dated 10/22/24, reflected a BIMS score of 5, indicating a severe cognitive impairment. Section I (Active Diagnoses reflected she did not have a seizure disorder, epilepsy, or a psychiatric/mood disorder. Section N (Medications) reflected she was not on insulin or antipsychotics. Section O (Special Treatments, Procedures, and Programs) reflected she required dialysis. Review of Resident #1's admission care plan, dated 10/24/24, reflected she had diabetes and was at risk for complications associated with diabetes with an intervention of administering her medications as recommended by her doctor. It further reflected she ESRD (End Stage Kidney Disease) and required dialysis treatments with an intervention of giving medications as ordered by her physician. Review of Resident #1's Admission/Readmission Assessment, dated 10/18/24 and documented by LVN A, reflected she did not have a diagnosis of diabetes. Review of Resident #1's hospital discharge paperwork, dated 10/18/24, reflected an order for Novolin 70/30 FlexPen - 100 Unit/ML injection - Inject 8 units under the skin before breakfast and before evening meal and an order to check blood sugar four times a day. There was not an order for an anti-seizure medication. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's physician order, dated 10/19/24, reflected Lacosamide Oral Tablet - Give 1 tablet by mouth one time a day for seizures. Review of Resident #1's October MAR, on 12/03/24, reflected she was administered four doses of Lacosamide - on 10/20/24, 10/21/24, 10/23/24, and 10/24/24. Review of Resident #1's physician order, dated 10/19/24, reflected Divalproex Sodium Oral Tablet Delayed Release - 500 MG - Give 1 tablet by mouth one time a day for seizures. Review of Resident #1's October MAR, on 12/03/24, reflected she was administered five doses of Divalproex - from 10/20/24 - 10/24/24. Review of Resident #1's physician order, dated 10/24/24 at 1:50 PM (after Resident #1 had been discharged to the hospital), reflected Novolin 70/30 FlexPen - 100 UNIT/ML - Inject 10 units subcutaneously two times a day for DM. Review of Resident #1's blood sugar readings in her EMR, on 12/03/24, reflected the following: 10/19/24 7:45 AM - 114.0 mg/dL 10/19/24 4:52 PM - 125.0 mg/dL 10/23/24 6:58 AM - 562.0 mg/dL 10/23/24 8:37 PM - 397.0 mg/dL 10/24/24 7:40 AM - 186.0 mg/dL 10/24/24 10:34 AM - 485.0 mg/dL 10/24/24 11:26 AM - 485.0 mg/dL Review of Resident #1's Change in Condition Assessment, dated 10/24/24 and documented by LVN B, reflected the following: [Resident #1] barely talking but verbally responsive with [NP] after this nurse notified [NP] of s/s of lethargy. [NP] came to [Resident #1] and talked to [Resident #1]. N/o to send to (hospital). Mental Status Evaluation: Altered level of consciousness - Sudden change in level of consciousness or responsiveness. Describe functional status changes: Needs more assistance with ADLs, general weakness, decreased mobility, and other. Describe the functional status signs or symptoms: weak and barely eating only sips of fluids and s/s of lethargy. . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Specify neurological changes: Weakness or hemiparesis (weakness of one side of entire body). Review of Resident #1's progress note, dated 10/24/24 at 9:15 AM and documented by LVN B, reflected the following: [Resident #1] with bs of 186 called [NP] and this nurse also notified [NP] of all bs since admit at this time r/t high and out of normal range . Review of Resident #1's progress note, dated 10/24/24 at 9:22 AM and documented by LVN B, reflected the following: .[NP] notified that [Resident #1] is not talking and very weak and not as responsive . Review of Resident #1's progress note, dated 10/24/24 at 9:35 AM and documented by LVN B, reflected the following: DON speaking with [NP] about changes. [NP] notified this nurse to send resident to (hospital) with dx of lethargy . Review of Resident #1's progress note, dated 10/24/24 at 4:11 PM and documented by LVN B, reflected the following: Call out to (hospital) for 3rd update on resident and this time this nurse spoke with resident [sic] being admitted with dx of sepsis, ams, and hypotension . Review of Resident #1's hospital records, dated 10/24/24, reflected the following: .presented to ED on 10/24/24 presentation concerning for sepsis with subsequent blood cultures showing Gram-positive organisms . However [Resident #1] is unable to have oral intake because of weakness at this point as well as change in mental status and we will reassess. A1C - 14.7 (Reference Range: 3.0 - 5.6) Received 6 units of Insulin Lispro on 10/24/24 at 9:15 PM. During an interview on 12/03/24 at 10:46 AM, the IDON stated if a resident was prescribed Divalproex and Lacosamide they should have a diagnosis or history of seizures. During an interview on 12/03/24 at 10:54 AM, the WCN stated if a resident was being administered seizure medications with no seizure diagnosis, it could cause a resident to have an anticholinergic effect (symptoms include delirium, confusion, restlessness, it suppressed the central nervous system in different ways for different people) or to become sedated. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/03/24 at 12:04 PM, Resident #1's NP stated she reviewed resident vitals such as blood sugars and blood pressures every month. She stated if a resident was on a sliding scale insulin, there were parameters on how much insulin was to be administered. She stated if a resident's blood sugar was consistently elevated, even if not over 400, then most of the time the nurses would notify her. She stated if a resident was not on insulin and their blood sugar was over 200, she would expect to be notified. She stated if a resident was admitted from the hospital with insulin orders, they would not all the time immediately keep those orders in place. She stated if they had a normal A1c they would just monitor their sugar levels. She stated but if they did come with orders for insulin, they would follow the orders and adjust as needed. She stated it was just a case-by-case basis. She stated Lacosamide was medication utilized strictly for seizure disorders, but Divalproex could be used for behavioral issues. She stated if a resident did not have a history of seizures and was administered seizure medication, they could have an allergic reaction to the medication, but as for other symptoms, it would just depend on the possible side effects of the medication. She stated every body's chemical makeup was different and it just depended. She stated she was the one that gave the orders to send Resident #1 to the hospital on 10/24/24. She stated lethargy was her baseline since admission but that morning she could not be aroused and could barely open her eyes. She stated she was aware her blood sugars had been elevated but she (Resident #1) had not been at the facility long and they had not gotten there yet (when it came to prescribing insulin). During a telephone interview on 12/03/24 at 1:23 PM, Resident #1's MD stated it was not uncommon for a resident to not have orders for insulin even after they were on insulin in the hospital because they were going from the hospital to a post-acute world. He stated it was also very difficult with a dialysis patient because there were so many variables such as the dynamic fluid shift due to dialysis. He stated if Resident #1's blood sugars were in the 300 - 500 range, that would be way higher than it should be. He stated he would not have agreed at that at all (to not instate insulin at that point). He stated a resident would not be started on anti-seizure medication in a post-acute setting unless they were on them in the hospital. He stated if a resident was on these medications without a diagnosis of epilepsy/seizures it would typically cause sedation as they alter brain waves. He stated that could have 100% caused Resident #1's hospitalization and he wondered if the orders got transcribed in error. During an interview on 12/03/24 at 4:58 PM, the IDON stated the nurse admitting a resident was responsible for inputting medication orders after reconciling with the NP or MD. She stated the admitting nurse would only add or take away orders if the NP/MD told them to. She stated it depended on what the medication was when asked what a negative outcome of inputting inaccurate orders could be. She stated she would have to ask a doctor what a negative outcome could be for a resident to be administered anti-seizure medication without a diagnosis of seizures. She stated all medications had a potential for side effects. On 12/04/24 and 12/05/24, multiple attempts were made to contact LVN A. A returned phone call was not received prior to exiting. Review of the facility's Medication Administration Policy, revised January 2024, reflected the following: Resident medications are administered in an accurate, safe, timely, and sanitary manner. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM and IDON were notified on 12/03/24 at 5:19 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 12/05/24 at 10:50 AM: F760 - The facility must ensure that residents are free from significant medication errors. Immediate Response: Resident # 1 was discharged to the hospital on 10/24/24. Director of Clinical Operations reviewed with the clinical leadership- Assistant Director of Nursing regarding the proper process for: o Licensed nurse should conduct appropriate medication reconciliation as well as blood glucose monitoring orders in relation to the hospital discharge orders and the nurse should ensure that all hospital discharge orders to include medications, treatments and blood glucose monitoring orders are reviewed and confirmed with the accepting attending physician upon admission. o Post reconciliation of the medication/treatment/blood glucose monitoring order the licensed nurse should review each medication and/or treatment and blood glucose monitoring orders as well as insulin orders, to ensure that they are accurately transcribed as per the hospital discharge orders as well as any new orders provided by the attending physician / medical provider are accurately transcribed into the electronic health record. o Clinical leadership/assigned licensed nurse will conduct a post admission review all new admission/re-admission orders to include but not limited to insulin orders, blood glucose monitoring orders, correct medication orders and treatment orders against the hospital discharge order to validate the accuracy of medication reconciliation and proper transcription of physician orders. Should any discrepancies be identified, the licensed nurse should immediately report the discrepancy, clarify with the attending physician/medical provider and complete a medication error report as indicated. o Abuse & Neglect and Medication Administration, Accurate transcribing of physician orders. Date commenced: 12/3/2024. Date completed: 12/4/2024. The Director of Clinical Operations/ Assistant Director of Nursing initiated in-service training for licensed nurses regarding the process for: o Licensed nurse should conduct appropriate medication reconciliation as well as blood glucose monitoring orders in relation to the hospital discharge orders and the nurse should ensure that all hospital discharge orders to include medications, treatments and blood glucose monitoring orders are reviewed and confirmed with the accepting attending physician upon admission. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Post reconciliation of the medication/treatment/blood glucose monitoring order the licensed nurse should review each medication and/or treatment and blood glucose monitoring orders as well as insulin orders, to ensure that they are accurately transcribed as per the hospital discharge orders as well as any new orders provided by the attending physician / medical provider are accurately transcribed into the electronic health record. o Clinical leadership/assigned licensed nurse will conduct a post admission review all new admission/re-admission orders to include but not limited to insulin orders, blood glucose monitoring orders, correct medication orders and treatment orders against the hospital discharge order to validate the accuracy of medication reconciliation and proper transcription of physician orders. Should any discrepancies be identified, the licensed nurse should immediately report the discrepancy, clarify with the attending physician/medical provider and complete a medication error report as indicated. o Abuse & Neglect and Medication Administration, Accurate transcribing of physician orders. Date commenced: 12/3/2024. Date completed: 12/4/2024. Licensed nurses will complete a test to validate the process for proper process for medication reconciliation, confirming orders upon admission/re-admission and transcribing orders into the electronic health record in order to validate competency of the facility's expected practices. Date Commenced: 12/4/2024 and ongoing. Director of Clinical Operations / Assistant Director of Nursing will conduct 100% audit of all current in-patient new admissions / re-admissions' medication and treatment orders reconciliations to validate accuracy of the admission / re-admission orders entered into the electronic medical record. Outcome: Date Completed: 12/4/2024. Director of Clinical Operations / Administrator suspended the licensed nurse pending investigation who was responsible for completing an accurate medication reconciliation and accurately entering the correct hospital discharge orders after confirming the medication and treatment orders with the accepting medical provider upon admission. Date completed: 12/3/2024. Director of Clinical Operations / Assistant Director of Nursing will provide the same in-service trainings with all newly hired licensed nurses going forward as a part of the on-boarding process for nurses. Date commenced: 12/3/2024. Date completed: 12/4/2024 and ongoing. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Director of Clinical Operations / Assistant Director of Nursing will ensure all licensed nursing staff will be re-educated to include any licensed nurse on leave/agency/PRN staff. All licensed nurses will be in-serviced prior to assuming next shift. Director of Clinical Operations/Administrator will ensure administrative nursing staff is available to provide in-service/education prior the licensed nurses working their next assigned shift. Risk Response: All residents who are newly admitted or readmitted have the potential to be affected by the deficient practice. Systemic Response: Director of Clinical Operations / Assistant Director of Nursing initiated in-service training for licensed nurses regarding the process for: o Licensed nurse should conduct appropriate medication reconciliation as well as blood glucose monitoring orders in relation to the hospital discharge orders and the nurse should ensure that all hospital discharge orders to include medications, treatments and blood glucose monitoring orders are reviewed and confirmed with the accepting attending physician upon admission. o Post reconciliation of the medication/treatment/blood glucose monitoring order the licensed nurse should review each medication and/or treatment and blood glucose monitoring orders as well as insulin orders, to ensure that they are accurately transcribed as per the hospital discharge orders as well as any new orders provided by the attending physician / medical provider are accurately transcribed into the electronic health record. o Clinical leadership/assigned licensed nurse will conduct a post admission review all new admission/re-admission orders to include but not limited to insulin orders, blood glucose monitoring orders, correct medication orders and treatment orders against the hospital discharge order to validate the accuracy of medication reconciliation and proper transcription of physician orders. Should any discrepancies be identified, the licensed nurse should immediately report the discrepancy, clarify with the attending physician/medical provider, and complete a medication error report as indicated. o Abuse & Neglect and Medication Administration, Accurate transcribing of physician orders. Date commenced: 12/3/2024. Date completed: 12/4/2024. Director of Clinical Operations / Assistant Director of Nursing will conduct 100% audit of all current in-patient new admissions / re-admissions' medication and treatment orders reconciliations to validate accuracy of the admission / re-admission orders entered into the electronic medical record. Outcome: Date Completed: 12/4/2024. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Director of Clinical Operations / Assistant Director of Nursing will provide the same in-service trainings with all newly hired licensed nurses going forward as a part of the on-boarding process for nurses. Date commenced: 12/3/2024. Date completed: 12/4/2024 and ongoing. Director of Clinical Operations / Assistant Director of Nursing will ensure all licensed nursing staff will be re-educated to include any licensed nurse on leave/agency/PRN staff. All licensed nurses will be in-serviced prior to assuming next shift. Director of Clinical Operations/Administrator will ensure administrative nursing staff is available to provide in-service/education prior the licensed nurses working their next assigned shift. Monitoring: Director of Clinical Operations /Assistant Director of Nursing will conduct random weekly (1-7 days per week for 2 weeks) audit of new admission / re-admission physician orders to validate the accuracy of the medication reconciliation and transcription process of the physician/medical provider confirmed orders within the E.H.R against the hospital discharge orders to validate medication, insulin and treatment accuracy. The Director of Clinical Operations / Assistant Director of Nursing will maintain a monitoring log of the audits conducted identifying compliance throughout the monitoring period. Director of Nursing/Assistant Director of Nursing will conduct daily reviews during clinical start-up meeting (1-7 days per week for 2 weeks) review of new / re-admission orders, progress notes, and the 24-hour report to ensure that appropriate interventions and/or all needed follow up has been assigned. The Director of Clinical Operations / Assistant Director of Nursing will maintain a monitoring log to validate that the daily (1-7 days per week) monitoring has taken place and the outcome of the review, identifying any related compliance issue. This monitoring plan will remain in place for the next 2-3 months to ensure compliance or to identify additional training needs. All findings will be reported to the QAPI committee during monthly meeting for the next 2-3 months. Administrator, Director of Clinical Operations, and the Medical Director conducted an Ad Hoc QAPI meeting to review the identified deficient practice and plan of removal (corrective action plan) implemented. Date of completion: 12/4/2024. The Surveyor Monitored the POR on 12/05/24 as followed: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 12/05/24 from 2:03 PM - 4:46 PM, six LVNs and eight CNAs from multiple shifts stated they were in-serviced on multiple topics prior to their shifts. They all stated they were in-serviced by the DCO on abuse and neglect and the ADM was their Abuse and Neglect Coordinator. They gave examples of abuse such as physical, sexual, financial, or verbal. The LVNs all stated they were in-serviced on medications upon admissions and readmissions. They stated they needed to get the provider to verify all orders that would be sent to the pharmacy. They stated the most important thing was to ensure the residents had the correct orders for medications. They stated now they would have a second nurse look at the orders while verifying/reconciling with the provider. Review of the facility's Ad Hoc QAPI meeting Agenda, dated 12/03/24, reflected the ADM, the DNS, key nursing leadership, and the MD were in attendance. Review of the audit of all current in-patient new admissions/re-admissions' medication and treatment orders to validate accuracy of orders, dated 12/04/24, reflected no concerns. Review of an in-service entitled Abuse and Neglect, from 12/03/24 - 12/04/24 and conducted by the DCO (IDON), reflected nursing staff from all shifts were educated on the facility's Abuse and Neglect policy. Review of an in-service entitled Medication Administration, from 12/03/24 - 12/04/24 and conducted by the DCO, reflected nursing staff from all shifts were educated on the facility's Medication Administration policy. Review of an in-service entitled Medication Administration, from 12/03/24 - 12/04/24 and conducted by the DCO, reflected nursing staff from all shifts were educated on accurately transcribing physician orders upon admissions and readmissions. Review of Charge Nurse Admit/Readmit Competency Checks, from 12/03/24 - 12/04/24, reflected all nurses passed the competency checks regarding physician orders and reconciling medication orders. Review of an e-mail sent by the ADM, dated 12/05/24 at 4:11 PM, reflected at that time 81% of their CNAs and 90% of their nurses had been in-serviced and the rest would be in-serviced before working the floor. The ADM and DON were notified on 12/05/24 at 5:29 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.