STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675935	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Haltom	2936 Markum Dr Fort Worth, TX 76117

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 8 residents (Resident #17) reviewed for advanced directives, in that: Resident #17's Out-of-Hospital Do Not Resuscitate (OOHDNR) was not dated by the resident and the physician at the time it was signed, rendering the document invalid. This failure could place residents at-risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. The findings include: Record review of Resident #17's face sheet, dated [DATE], indicated Resident # was an [AGE] year-old female with an admitted [DATE]. Further review of Resident #17's face sheet, revealed under the section, ADVANCE DIRECTIVE: DNR. Record review of Resident #17's Quarterly MDS, dated [DATE], revealed the resident's BIMS score was 09, which indicated moderate cognitive impairment. Resident # diagnosis included Non-Alzheimer's Dementia, Anxiety Disorder, Depression, Psychotic Disorder, and Schizophrenia. Record review of Resident #17's Care Plan, with last revised on [DATE], revealed, Resident has Advanced Directives CPR-Full Code, Goal: Resident #17's Advance Directives will be honored. Intervention included: Code status will be reviewed on a quarterly basis and as needed; Resident has decided to remain a Full Code. Review of Resident #17's Order Summary Report, Active Orders as of [DATE], revealed an order, DNR, dated [DATE] with no end date. Record review of Resident #17's electronic clinical record revealed there was not an OOH-DNR (Out-Of-Hospital Do-Not-Resuscitate Order), signed by Resident #17. Record review of Resident #17's paper clinical record revealed there was an OOH-DNR (Out-Of-Hospital Do-Not-Resuscitate Order), signed by Resident #17, two witnesses and the physician. Further review revealed in Section A Resident #17's signature was dated [DATE]; the physician and two witness's signatures were dated [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on [DATE] at 9:45 AM with the Social Worker revealed Resident #17's face sheet indicated her Advanced Directive status was DNR. The Social Worker further reviewed the care plan and responded, the care plan indicated Resident #17 was Full Code. The Social Worker was asked to review Resident #17's DNR, it was signed and dated [DATE] by Resident #17, however review of the physician and two witness signatures revealed a date of [DATE]. Social Worker stated after the DNR was signed, nurses should have given the document to her so she could provide medical records a copy to upload to the resident's electronic chart. The Social Worker stated it was the responsibility of the nurses to update the system to reflect resident's code status. According to the Social Worker, not doing so would place Resident's choice not to be honored in a life determining situation. The Social Worker further stated since the document was not dated accurately it voided the DNR. In an interview on [DATE] at 11:25 AM with the MDS Coordinator revealed she was notified by the Social Worker that Resident #17's Advance Directive code status indicated DNR on the face sheet, but indicated she was Full Code in her care plan. MDS Coordinator stated at that time she checked Resident #17's order and then updated the care plan to accurately reflect DNR. The MDS Coordinator was asked to review Resident #17's DNR, after review of the document, MDS Coordinator stated she would need to notify the DON because the document was not valid due to the two different dates of signature. MDS Coordinator stated the DNR was not valid because the document had to be signed at the same time, on the same date. MDS Coordinator stated it was her responsibility to update the care plan to reflect the proper Advance Directive code status, not doing so placed the resident at risk of not have the correct code status. In an interview and record review with the DON on [DATE] at 11:35 AM the DON stated she was not aware of the DNR on the face sheet being different from the Full Code status in the care plan. The DON reviewed the DNR and confirmed all sections of the OOH-DNR must be fully completed and signed at the same time to be valid. In a follow up interview on [DATE] at 11:50 AM the DON stated Resident #17's Advance Directive code status had been changed to Full Code to reflect the care plan due to the discrepancies of the dates. The DON stated after reviewing the document it appeared someone besides Resident #17 may have printed Resident #17's name and dated the form [DATE]. The DON stated in order to have accuracy the form would need to be redone. According to the DON, it was the responsibility of the nursing staff to ensure they were aware of all resident's code status, not doing so would place residents at risk of not having their Advanced Directive honored. In an interview on [DATE] at 3:13 PM with the Administrator revealed he was notified about Resident #17's DNR discrepancy. The Administrator stated upon review of the document, it was not valid due to the date of Resident #17's signature did not indicate it was signed on the same date as the physician and witnesses. The Administrator stated the Social Worker was responsible for reviewing and ensuring resident DNRs were up to date and accurate during care plan meetings. The Administrator stated not doing so placed residents at risk of not receiving accurate life saving measures. Record review of the facility's policy titled, Advance Directives and Advance Care Planning, revised [DATE], revealed, Residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Community education and awareness efforts per the Patient Self-determination Act and state-specific laws on advance directives will be coordinated by the Social Services Director .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to respect the resident's right to personal privacy for 1 of 1 resident (Resident #54) reviewed for privacy issues in that: RN A failed to provide full privacy for Resident #54 during intravenous medication administration by not closing privacy curtains or door during care. This failure could cause residents to feel uncomfortable, disrespected, and possible exposure to anyone passing by. Findings include: Record review of Resident #54's MDS, dated [DATE], reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE] with a readmission on 09/25/24. The resident's diagnoses included: wound infection and multi-drug resistant organism. The resident was cognitively intact with a BIMS score of 15. Record review of Resident #54's care plan, dated 07/30/34, reflected: The resident is on IV Medications r/t skin infection on groin area and is at risk for complications. The resident will have not had any complications related to IV therapy through the review date. The interventions did not include provisions for privacy. Observation of RN A on 10/09/24 at 8:34 AM revealed she sanitized and gathered supplies to provide Resident #54 with IV medication administration. She knocked on the door, sanitized, and put on PPE. She entered the resident's room and explained the procedure to the resident. Without closing the door to the resident's room. She removed her gloves, washed her hands, and put on new gloves. She prepared the medication and attached bag to the pumping machine. She cleansed the resident's PICC line with alcohol, flushed the PICC line, and then she connected the tubing. RN A did not close the door and did not pull the privacy curtain to cover the bed. She removed her PPE, washed her hands, labeled the bag and the tubing with date time and initials, sanitized, and left the room. Interview with RN A on 10/09/24 at 8:46 AM revealed she knew she was supposed to provide privacy, but she forgot. She stated she was nervous having with two surveyors observing her. She stated she could have pulled the curtain for dignity for Resident #54. RN A stated she had training on resident rights and privacy. Interview with DON on 10/09/24 at 3:51 PM revealed she expected staff to close the door, close the blinds, close all curtains, and cover the resident to provide privacy. The DON stated the negative potential outcome would be that resident's may not want other people to see their business and may also cause them to become embarrassed. The DON stated that the facility provides training. Record review of facility's Resident Rights policy, revised 09/10/24, reflected the following: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodation, medical treatment, personal care but this does not require the facility to provide a private room for each resident.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goal and preferences for 1 of 2 resident (Resident #120) reviewed for pharmacy services. The facility failed to ensure Resident #120's intravenous medication bag was labeled with date, time, and initials. These failures could place residents at risk for medication error, and delay in medication administration. Findings included: Record review of Resident #120's entry MDS assessment, dated 09/26/24, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses including which included: encounter for surgical aftercare following surgery on digestive system. Resident #120 BIMS score was not indicated. Record review of Resident #120's physician's orders dated 10/05/24 reflected an order for: (meropenem 1-gram intravenous solution (1) vial every eight hours for 21 days), (change intravenous tubing every 24 hours) and Vancomycin intravenous solution 1250mg/250ml every 12 hours for 21 days)" Observation on 10/08/24 at 11:08 AM revealed Resident #120 in her room, lying in bed. She was observed to have a PICC line dated 10/07/24. The intravenous medication bag was hanging on the pole. The IV bag was not labeled with the date, time, and initials to indicate when it was hung and another empty bag was hanging not dated or labeled. Observation on 10/08/24 at 2:36 PM revealed Resident #120 in her room, lying in bed. The intravenous medication bag was hanging on the pole. The IV bag was not labeled with the date, time, and initials to indicate when it was hung. Observation and interview on 10/08/24 at 3:00 PM with RN F revealed she was not the one who hung the bag currently infusing. She stated she saw the unlabeled, empty bag hanging on the pole. It was hung by the 6:00 AM-2:00 PM nurse. RN F said the IV bag was supposed to have the correct resident's name, date, time and initial of the nurse administering the medications. She stated failure to put the date time and initial could make Resident #120 miss the next dose or get overdose since she was not aware when she got the last dose. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/09/24 at 11:23 AM with RN G revealed he hung the bag of Vancomycin at 8:00 AM and another for meropenem 1-gram at 2:00 PM that he had left infusing. He stated he was aware he was supposed to label the bag and the tubing with date, time, and initials, so other staff were aware when the bag was hung to prevent omission of a dose or overdose, but he did not. He stated he forgot because he was in a hurry to catch up with passing the other medications to other residents although that was not an excuse. He stated he was supposed to do the right thing. He stated failure to label the bag and the tubing could lead to overdose, omission of a dose and infection. He stated the tube was changed as scheduled and was good for every 24 hours as per the orders RN G stated he had done training on IV administration. Interview on 10/09/24 at 3:51 PM with the DON revealed she expected staff to date and initial intravenous bags and tubing when administering intravenous medications to prevent infection, overdose, and medication error. She stated the tubing should be changed every 24 hours. She stated she had done training with staff on labeling and putting initials on bags and tubing and, she had done skill checks with the nurse on 02/23/24. Record review of the facility's training record reflected an in-service training regarding IV/PICC Lines on 08/12/24, which reflected: remember to date, initial and time all tubing's and medication. Record review of the facility's current Admixing IV Medication policy, dated 05/01/24, reflected the following: .11.Gently rotate solution container to thoroughly mix medication. If pharmacy label already attached, nurse to add initials, time, and date mixed/activated. If label not attached, complete a medication added label with the following information: 11.1 Patient's name 11.2 IV solution/volume/diluent 11.3 Medication added 11.4 Medication dose 11.5 Route and rate 11.6 Directions for administration 11.7 Time medication added 11.8 Date medication added 11.9 Date and time of administration 11.10 Expiration date and time 11.11 Initials of nurse preparing/administering medication"

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 4 residents (Resident #20) reviewed for dialysis. The facility failed to ensure post-dialysis assessments were completed for Resident #20 after returning from dialysis treatment. This failure could place residents at risk of inadequate post dialysis care. Findings included: Record review of Resident #20's EHR reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #20 had a diagnosis of end stage renal disease (a chronic condition that occurs when the kidneys can no longer filter waste from the blood and requires long-term dialysis or a kidney transplant to maintain life). Record review of Resident #20's quarterly MDS assessment, dated 08/23/24, reflected a BIMS score of 0, which indicated his cognition was severely impaired. The MDS reflected Resident #20 received dialysis. Record review of Resident #20's care plan, dated 09/24/24, reflected Resident #20 needed hemodialysis (medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly). Resident #20 will have no signs of complication from dialysis through next review. Facility will send completed dialysis communication sheet/book with resident. Staff will obtain completed dialysis communication sheet from dialysis center. Record review of Resident #20's July 2024 physician's order reflected orders for post dialysis monitoring, assess bruit/thrill upon return from dialysis. Check site for bleeding, and infection. Record review of Resident #20's EHR reflected no nursing documentation regarding Resident #20's post-dialysis vital signs on the missing forms. Record review of Resident #20's dialysis communication forms from 08/22/24 to 10/10/24 reflected dialysis communication forms with resident assessment and observation post-dialysis section for August on 08/26/24 and 08/28/24, for September on 09/02/24, 09/06/24 and 09/20/24 and for October on 10/02/24 and 10/09/24 all the other dialysis dates of the month of August,September and October were missing communication forms totalling to one day in August, eleven days in September and two days in October. Interview on 10/08/24 at 10:14 AM with Resident #20 revealed he went for dialysis Monday, Wednesday, and Friday. He stated he got a form that he took to dialysis and brought back to facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/11/24 at 01:04 PM with LVN D revealed she was aware she was supposed to send Resident #20 with the dialysis communication form when he left for dialysis and then collect the form when the resident returned from dialysis. LVND stated she knew she was supposed to monitor the dialysis access site for the bruit thrill (a vibration caused by blood flowing through the fistula and can be felt by placing your fingers just above incision line), dressing for bleeding and vital signs when Resident #20 was back from dialysis. She stated it was all nurse's responsibility to update the dialysis communication form when Resident#20 came back and, they give them to RN H who was responsible of ensuring they are given to medical records for uploading to electronic health records. LVN D stated failure to fill the communication form after dialysis they could miss the orders from dialysis and if not monitoring after dialysis Resident #20 post dialysis put him at risk of low blood pressure, infection, and bleeding. She stated she had done trainings, on dialysis communication form. Interview on 10/10/24 at 02:05 PM with the RN H revealed all nurses were responsible for filling out the forms pre- and post-dialysis. She stated it was her responsibility to ensure the staff completed post-dialysis communication forms when Resident #20 returned to the facility. RN H stated she went through the dialysis communication forms after dialysis. She stated the nurses were supposed to put the forms in her office or in the resident binder. She stated she then collected them and went through them, from there go through forms before she giving to the medical record for uploading. She stated she did not document what she had received and what was missing, so she could not tell whether there some that were missing. RN H stated the communication forms were important to ensure the vital signs were stable, check for bleeding and it was the communication between dialysis and the facility. She stated the risk for not assessing the vitals was Resident #20's vital signs could be unstable leading to change of condition and the nurses could miss orders from dialysis H stated she did in-service training with staffs on 9/13/24. Interview on 10/10/24 at 02:16 PM with the DON revealed her expectation was for the nurses to perform post-dialysis assessments when residents returned from dialysis, and document on dialysis communication forms on dialysis days. She stated RN H from management and her were responsible of following up with nurses and ensuring the post dialysis monitoring was being done and documented, on the dialysis communication form. She stated RN H was supposed to check and follow up with nurses. The DON stated failure to monitor the vital signs after dialysis would lead change of condition, bleeding, and unstable vital signs and they could miss important orders form dialysis center. She stated facility had done training with staff and the last in-service was in September 2024. Record review of the facility trainings reflected the facility had done training on the Dialysis communication form on 09/13/24. Record review of the facility's Hemodialysis offsite policy, dated 08/23/23, reflected the following: Day of dialysis, .2 observe vascular access site prior to dialysis and initiate the pre/post dialysis communication form to be sent to the dialysis clinic with the resident. (med pass form #LCCA-528). Post dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain vital signs of resident upon return from dialysis and complete the pre/post dialysis communication form. (med pass form #LCCA-528).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42859 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 4 of 4 medication carts (Hall A, Hall D, Hall E, and Hall F medication carts) and establishing a system of records receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation one of one storage area for drugs pending destruction (DON's office) reviewed for storage of medications 1. The facility failed to ensure insulin pens that were opened and used for Hall E and Hall F were labeled with opening dates. 2. The facility failed to ensure expired medications (sodium carbonate, nitroglycerin, and calcium) stored on the the Hall A and Hall D medication carts were securely stored and reconciled. 3. The facility failed to ensure Resident #2's morphine (liquid concentrate) was reconciled after she expired on 09/13/24, as evidenced by the bottle containing 18 ml and the narcotic log showing 20 ml. The failures had the potential to result in drug diversion and decreased therapeutic efficacy. Findings included: 1. Observation with RN N on 10/09/24 at 1:51 PM revealed the Hall E medication cart had two vials of insulin glargine and Lantus solution 100 unit/ml opened and partially used. These insulins did not have date on them indicating when they were opened. Observation with RN N on 10/09/24 at 1:57 PM revealed the Hall F medication cart F had two vials of insulin Humalog Kwik pen and Lantus solution 100 unit/ml opened and partially used. These insulins did not have date on them indicating when they were opened. Interview on 10/09/24 at 2:04 PM with RN N revealed it was the responsibility of all nurses to date insulin when they were opened. RN N stated she did not open the pen, and she did not check to see if there was an open date at the beginning of her shift. She stated she was supposed to check her cart every shift. RN N stated the purpose of putting an open date was for expiration purposes because the insulin was short acting and was only good for 28 days. She stated if the insulin was expired then it would not be effective, and nurses would not know when it was opened or when it should be discarded. Interview on 10/10/24 at 10:43 AM with LVN K revealed it was her responsibility to check the medication carts for Hall E and Hall F. She stated she last checked the cart on 10/08/24, and she expected the nurses to check the carts every shift for insulin opening dates. 2. Observation with LVN D on 10/09/24 at 1:51 PM revealed the medication cart for Hall A had the following expired medication: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1 bottle calcium 600 mg with expiry date of 09/24, Observation with LVN D on 10/09/24 at 2:29 PM revealed the medication cart for Hall D had the following expired medications: - 1 bottle sodium carbonate 325 mg with expiry date 09/24, and - 1 bottle Nitroglycerin 0.4 mg tablet with expiry date 09/24. Interview on 10/09/2024 at 2:46 PM with LVN D revealed it was the responsibility of all nurses to ensure expired medications were removed from the cart and put in destruction boxes. She stated she was expected to check the cart each shift, but she did not check. LVN D stated the outcome for administering expired medications would be that the medication would not be as effective. Interview on 10/10/24 at 10:57 AM with RN H revealed it was her responsibility to check the cart for Halls A and D. She stated she last checked the cart on 10/08/24, and she could have missed the expired medications. She stated she expected the nurses to check the medication carts every shift for labeling and removal of the expired medications. She stated the risk of administering expired medications would be that the medication would not be potent. She stated she had done training regarding expired medication removal. Interview on 10/09/24 at 3:58 PM with the DON revealed it was her responsibility to follow behind the nurses and check the carts for expired medications. She stated she also had managers, to whom she delegated for each hall, and last time they checked the carts was on 10/08/24. She stated her expectation was for the nurses to check their carts each shift for expired medications. She stated the risk of administering expired medications would be that the medication would not be effective. 3. Record review of Resident #2's Quarterly MDS Assessment, dated 06/14/24, reflected the resident was a [AGE] year-old female, who admitted to the facility on [DATE]. The resident received hospice services, and she expired on 09/13/24. Record review of Resident #2's physician orders, dated 09/11/24, reflected orders for morphine sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate), 0.25 ml to be given every 2 hours as needed for mild to severe pain. Observation and record review with the DON on 10/09/24 at 3:21 PM revealed the narcotic medication stored in her office pending destruction with the Pharmacist, when reconciled with the narcotic log, revealed Resident #2's morphine solution was not balancing with the count on the narcotic log. The narcotic log reflected there were 20 ml remaining, whereas, the amount in the vial revealed 18 ml remaining. (continued on next page)

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	675935	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Haltom	2936 Markum Dr Fort Worth, TX 76117

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/09/2024 at 3:45 PM with DON revealed it was her responsibility to ensure the narcotic count balanced with the narcotic log. She stated she was expected to log all narcotics for destruction as she got them from nurses, but she did not as she was busy. She stated when the morphine bottle was brought to her from the medication cart, she did not place it on a flat surface. She stated after looking at the bottle closely she could see the amount was less than 20 ml. She stated she trusted the nurse manager that was clearing the carts of all narcotics that were not in use, as a routine to clarify and sign the narcotic log with the nurse releasing the narcotics. She stated when the nurse manager brought the morphine and the narcotic log, she saw it was signed by both nurses. The DON stated the risk of not confirming the narcotic count before receiving the drugs could lead to drug diversion. She stated when she realized it she let management know, the incident was reported to police, the facility was investigating, and staff were being trained. Interview on 10/10/24 at 11:03 AM with RN H revealed she was the one, who cleared the carts of narcotics for destruction. She stated when she was notified on 10/09/24 of the discrepancy with the morphine, she checked on it. She stated she saw it did not balance with what was on the narcotic log. She stated it was her mistake because she did not check what was remaining when the resident died . RN H stated she signed the log as a witness with RN A. She stated she did not place the bottle on a flat surface to check what was remaining, which was her fault. RN H stated she could not remember counting with the DON when she gave her the narcotics for destruction. She stated she did not stick around to witness the DON counting. She stated failure to confirm the count could lead to drug diversion. Interview on 10/10/24 at 11:07 AM with RN A revealed she gave the narcotics that were due for destruction to RN H, and they both signed the narcotic administration log that read 20 ml. She stated she was not sure of what happened after that. She stated they were expected to both count and sign before removing the narcotice from the cart. RN H confirmed what the nurse was giving her. She stated it had been a long time since this happened, so she could not remember muc about it. She stated she had done training regarding expired medication removal. Record review of the facility's Management of Controlled Substances policy, dated 09/17/24, reflected the following: .5. The facility will ensure that the incoming qualified individual and outgoing qualified individual count all controlled substances and other medications with a risk of abuse or diversion at the change of each shift and whenever control of the controlled substances changes from one qualified individual to another (e.g., associate leaves facility for lunch break), using the Shift Change Controlled Substance Inventory Count Sheet. a. Reconcile the total number of controlled medications on hand, add newly received medications to the inventory, and remove medications that are completed or discontinued from the inventory; and b. Reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Shift Change Controlled Substance Inventory Count Sheet. c. The Facility should routinely reconcile the number of doses remaining in the package to the number of doses recorded on the Shift Change Controlled Substance Inventory Count Sheet, to the medication administration record. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Storage and Expiration Dating of Medications, Biologicals policy, dated 08/07/23, reflected the following: .5.3. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. .5.1 Facility staff may record the calculated expiration date based on date opened on the medication container. .15. Facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider. 16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law, and in accordance with Policy 8.2 (Disposal/Destruction of Expired or Discontinued Medication).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 1 of 6 residents (Resident #13) reviewed for infection control. CNA E failed to wear an N95 mask and eye protection when entering Resident #13's room who was COVID positive on 10/08/24. These failures could place residents at risk for infection and cross contamination. Findings included: Record review of Resident #13's Face Sheet, dated 10/10/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #13's admission MDS assessment, dated 09/23/24, reflected her diagnoses included displaced fracture of right lower leg, with routine healing, muscle weakness, and depression. Resident #13 had a BIMS score of 04, which indicates severe cognitive impairment. Record review of Resident #13's care plan, dated, 09/20/24, reflected Focus: Enhanced Barrier Precautions for surgical incisions requiring dressing. Goal: Staff will implement Enhanced Barrier Precautions as indicated. Interventions: Follow Enhanced Barrier Precautions protocol that is placed in front of the resident's door as indicated. Record review of Resident #13's physician orders revealed an order dated 10/04/24, Contact/Droplet precautions for Covid 19 every shift for Covid 19 + until 10/13/2024. Interview on 10/08/24 at 9:14 AM with the Administrator and the DON revealed the facility had one covid positive resident. The Administrator stated his expectations were for all staff to follow the signs on the door when utilizing PPE. Observation of Resident #13's room door on 10/08/2024 at 10:16 AM revealed there was PPE which included gown, gloves, N95 mask, and face shields outside resident's door. There was a sign next to the door which reflected information on what to do prior to entering the room, Special Droplet/Contact Precautions in addition to standard precautions. Everyone Must: Clean hands when entering and leaving room. Wear facemask at all times (N95 or higher). Wear eye protection. Gown and glove at door. Keep door closed. Observation on 10/08/24 at 11:45 AM of CNA E outside Resident #13's room revealed CNA E opened Resident #13's door and proceeded to put on a gown and gloves while the door was open. CNA E did not put on an N95 facemask or face-shield. CNA E closed the door, within 7 minutes CNA E opened the door, and she was observed mopping the floors. At 11:57 AM, CNA E removed the gown and gloves, exited the room, and then re-entered the room to wash her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/08/24 at 12:00 PM with CNA E revealed she was on light duty and was assigned to help housekeeping clean the resident's room. She stated she was unsure why Resident #13 was on isolation. She stated the signs on the doors indicated what to wear when entering the resident's room, she stated they did not have goggles and she forgot to put on a mask. She stated every month they had an infection control in-service. She stated the risk of not putting on a face-shield or facemask could lead to infection. Interview on 10/10/24 at 9:55 AM with LVN D stated she was the nurse assigned to Resident #13. She stated Resident #13 was in isolation due to being covid positive. She stated any staff who enter the room should don PPE which consisted of gown, gloves, face shield, and N95 mask prior to entering the room. She stated Resident #13 had PPE outside the door and a sign on the wall to indicate what to wear prior to entering the room. She stated staff were in serviced on infection control two days ago unsure of the exact date. She stated the risk of not donning PPE could lead the spread of germs. Interview on 10/10/24 at 1:52 PM with the Infection Preventionist stated the facility had one covid positive resident. She stated staff were expected to don PPE outside the door and doff the PPE inside the door. She stated the door should be always closed. She stated they had signs on the door to help staff know on what to don. She stated all staff were in-serviced 2 days ago (10/08/24). She stated the risk of not donning PPE was that it could lead to the spread of infection. Interview on 10/10/24 at 2:02 PM with the DON revealed staff were expected to don PPE which consisted of gown, gloves, N95 and face shield outside door and doff PPE inside the room. She stated the door should be closed the entire time. She stated signs were placed outside the residents' rooms to help staff on what to don. She stated staff were last serviced on 10/08/24. She stated the risk of not donning full PPE could lead to infection control. Record review of facility in-service Donning and Doffing PPE dated 10/08/24 revealed CNA E did not attend the training. Record review of facility policy Personal Protective Equipment (PPE) for SARS-COV-2 revised date 07/12/24 reflected the following: The facility will provide and utilize the appropriate PPE for the care of residents with COVID-19 in accordance with CMS and CDC guidance. The facility will provide and ensure associates use respirators and other PPE for exposure to residents with suspected or confirmed COVID-19. The facility will provide and ensure associates wear respirators for aerosol-generating procedures on a person with suspected and confirmed COVID-19. The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: 1. Respirator - a. Put on a N95 respirator (or equivalent or higher-level respirator) before entry into the patient room or care area, if not already wearing one as part of source control. (continued on next page)

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