STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676067	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mira Vista Court	7021 Bryant Irvin Rd Fort Worth, TX 76132

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 10 Residents (Resident #15) reviewed for quality of care. The facility failed to follow physician orders to apply an arm sleeve, used to protect skin, on Resident #15's right arm. This failure placed residents at risk of not receiving appropriate care and worsening of their conditions. Findings included: Review of Resident #15's Face sheet dated 05/31/24 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #15's quarterly MDS dated [DATE] revealed he had a BIMS score of 09, indicating moderate cognitive impairment. Further review revealed she had active diagnoses of unspecified symbolic dysfunctions, muscle wasting and atrophy, muscle weakness, local infection of the skin and subcutaneous tissue, unspecified. MDS assessment Section M - Skin condition indicated Resident #15 skin intact. Review of Resident #15's care plan revised on 05/20/24 reflected: Problem: Resident is a new admission. admitted from .Hospital. The resident's Baseline Care Plan will be developed within 48 hours of admission and provided to the resident and legal representative by completion of the comprehensive assessment. Goal: Resident's immediate health and safety needs will be identified. Approach: SKIN INTEGRITY: (X) Treatment-See Physician Orders. Review of Resident #15's physician orders, dated 04/12/24, reflected: Apply arm sleeve to right arm once a day, start time 7:00 AM (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's May 2024 TAR revealed Resident #15's was provided with her arm sleeve. No indication of refusal was documented. Observation on 05/28/24 at 8:39 PM of Resident #15 in bed with eyes closed. Observed Resident #15 right forearm skin to be dry/flaky rash there was no device (arm sleeve) in place. No open wounds observed. Observation on 05/29/24 at 9:00 AM revealed Resident #15 in the activity room seated in her wheelchair, and she was not wearing an arm sleeve on her right arm. Observation 05/29/24 at 12:58 PM of Resident #15 in the dining room. An attempt was made to interview Resident #15, but she was not able to answer questions. The skin on Resident #15's right forearm skin was dry/flaky with a rash, and the resident was not wearing an arm sleeve. Observation 05/30/24 at 8:40 AM of Resident #15 in the hallway. An attempt was made to interview Resident #15, but she was not able to answer questions. The skin on Resident #15's right forearm skin was dry/flaky with a rash, and the resident was not wearing an arm sleeve. Interview on 05/31/24 at 11:47 AM with LVN E revealed she was the nurse for Resident #15. She stated Resident #15 developed a rash on her right arm, and Resident #15 would scratch herself which cause her to have small scratches. LVN E stated the doctor had ordered for Resident #15 to wear a geri sleeve (arm sleeve) to prevent Resident #15 from scratching her arm. LVN E stated Resident #15 would only allow them to put lotion on and refuses the arm sleeve. LVN E stated she had not attempted to put the arm sleeve today (05/31/24) due to Resident #15 attending activities. LVN E stated Resident #15 had not had the arm sleeve the last few days due to Resident #15 refusing. LVN E stated she had documented incorrectly and should had document refusal. LVN E stated she was unsure what the risk would be for not putting the arm sleeve on Resident #15. Interview on 05/31/24 at 11:13 AM with the DON revealed Resident #15 had an order for an arm sleeve due to Resident #15 having a rash on her right arm. The DON stated Resident #15 would refuse the arm sleeve and would take it off. She stated her expectation was for the nurse to follow physician orders and attempt to put the arm sleeve on the resident. If Resident #15 refused, the nurses should document the refusal. She stated the risk of not utilizing the arm sleeve was that it could cause the rash to worsen. Interview on 05/31/24 at 12:28 PM with the ADON revealed Resident #15 had a physician order for a geri sleeve due to Resident #15 having a rash. She stated the geri sleeve was used to protect Resident #15 from scratching. She stated her expectation was for the nurses to follow physician orders. She stated if the resident refused, she expected the nurses to document not administered and to notify the physician of the refusal and discontinue the order. The ADON stated it was the responsibility of the nurses to put the geri sleeve on the resident, and it was the ADONs responsibility to ensure it was being completed. She stated the risk of not utilizing the geri sleeve was that it could cause irritation to the area to worsen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility Nursing Policies and Procedures policy, revised dated 05/05/23, reflected the following: Subject: Physician Orders. The qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines .Upon admission, the Facility has physician orders for the resident's immediate care to include but not limited to: A. Dietary orders B. Medications, if necessary C. Routine care orders to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an appropriate care plan.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one of three residents (Resident #47) reviewed for contracture management. The facility failed to apply rolled wash cloths to Resident #47's left contracted hand (a permanent tightening of the muscles) for contracture management. This failure could place residents at risk for a decline in range of motion, decreased mobility, worsening of contractures and a decline in physical capabilities. Findings included: Review of Resident #47's Face Sheet dated 05/31/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #47's quarterly MDS dated [DATE] revealed he had a BIMS score of 09, indicating moderate cognitive impairment. Further review revealed he had active diagnoses of sequelae of cerebral infarction, spastic hemiplegia affecting left dominant side, muscle weakness, other lack of coordination. The MDS further reflected the resident had functional limitation in range of motion upper extremity (shoulder, elbow, wrist, hand). Review of Resident #47's care plan revised on 04/25/24 reflected: Problem: ADLs Functional Status/Rehabilitation Potential Impaired physical mobility R/T contracture AEB limited range of motion. contracture of left hand, right knee, and left knee. Goal: Will be able to maintain current level of function through next review date. Approach: Monitor contracture for further contraction and report to MD. Place splints, carrot, washcloth to contracted area. Observation and interview on 05/28/24 at 8:36 PM revealed Resident #47 was in bed. He stated he was doing well. Observation of the resident's left hand revealed it was contracted, but there was no contracture management device in place. Resident #47 stated he was not sure if he needed a split; however, in the past staff would place a cloth in his hand. Resident #47 stated it had been a while since he last had one on. Resident #47 denied any pain or discomfort. Resident #47 revealed he had not refused to have anything placed in his left hand. Observation on 05/29/24 at 9:05 AM revealed Resident #47 in bed with his eyes closed. Observation of his left hand revealed it was contracted, but there was no contracture management device in place. Observation on 05/29/24 at 4:14 PM revealed Resident #47 in bed with his eyes closed. Observation of his left hand revealed it was contracted, but there was no contracture management device in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/31/24 at 10:06 AM of Resident #47 in bed. Observed Resident #47 left hand to be contracted there was no device in place. Resident #47 stated no one had place a washcloth in his left hand. Interview on 05/31/24 at 10:47 AM with LVN E revealed she was not sure if Resident #47 needed a washcloth or other devices for his left hand since she had never put one on. LVN E stated if Resident #47 was care planned to use a washcloth or other devices was because it was required and he needed it. LVN E stated it was the responsibility of the nurses or therapy to put them on. She stated Resident #47 was not on therapy. LVN E further stated it was important to keep the washcloths in the resident's hand to keep the contractures from worsening. Interview on 05/31/24 at 12:44 PM with the ADON B revealed they had recently ordered a splint for Resident #47; however, resident needed to be evaluated by therapy first before utilizing the splint. ADON B stated if Resident #47 was care planned to use a washcloth then it should be provided. She stated it was the nurse's responsibility to put in the washcloths, and it was her responsibility to ensure it was being provided to prevent contracture from worsening. Interview on 05/31/24 at 1:06 PM with the Director of Therapy revealed they had received Resident #47's elbow and knee splint yesterday 05/30/24. She stated they were just waiting on funding verification to be evaluated for services. She stated she was unaware of any splint or washcloth that Resident #47 needed for his left hand. She stated it would be nursing who was responsible. Interview on 05/31/24 at 1:15 PM with the DON revealed her expectation was for nursing staff to carry out the interventions in place that were listed for range of motion. She stated it was the responsibility of the nursing team to ensure interventions were in place for contractures. The DON stated she was aware of Resident #47's contractures, and therapy had ordered the appliances. She stated the risk of not following interventions would be further loss of joint mobility. Review of facility Restorative Nursing Policies and Procedures policy, dated 02/29/24, reflected the following: 1. Review care plan, determine the following: A. Active or Passive ROM exercises, B. Body Parts to be exercised, C. Number of repetitions, D. Special instructions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to ensure an environment remained as free of accident hazards as is possible for 1 of 26 resident rooms reviewed for a safe environment. The facility failed to ensure Resident #53 did not have access to facility disposable razors. This failure could place residents at risk of accidents, injuries, or harming another resident. Findings included: Record review of Resident #53's Admission Record revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] and reentered on 10/22/23. His diagnoses included lack of coordination, unsteadiness on feet, symptoms and signs involving cognitive functions and awareness, muscle weakness, hypertension (high blood pressure), unspecified atherosclerosis of native arteries of extremities, seizures, depression, restlessness, and agitation. Record review of Resident #53's Quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 04 which indicated severe impairment. The MDS also revealed, Resident #53, required supervision or touching assistance with transfer and activities of daily living. Record review of Resident #53's Care Plan revealed a problem initiated on 01/17/24 for risk of harm or injury related to seizure disorder. Resident #53 will not injure self-secondary to seizure disorder. Intervention included to administer medications as ordered, assess characteristics before, during and after seizure. If seizure occurs, remove all restrictive clothing and objects of potential harm. Resident #53 requires assistance with all activity of daily living related to general weakness and poor safety awareness. Resident will have all activities of daily living needs met. Interventions included assistance with bathing, and personal hygiene. Observations on 05/28/24 8:00 PM Resident #53 was sitting in his room, in wheelchair, with a disposable navy-blue razor in his hand shaving the left side of his face. According to Resident #53, he liked to use a razor to shave his face. Resident #53 stated he did not require shaving cream, that dry shaving was ok to do. Resident #53 stated he did not require assistance from staff to do so. Resident #53 was observed to check his face a couple of times, stating that he was making sure he did not cut himself. Observation on 05/29/24 at 3:20 PM of Resident #53 in his room sitting and watching television. A package of disposable razors was observed on the resident's bedside table. Interview on 05/29/24 at 3:29 PM with CNA F revealed she just left Resident #53's room and gave him ice. CNA F stated, I did not see him with razor or a package of razor. If I noticed anything like that, I would have removed the razors and reported to the nurse what I have removed. CNA F stated Resident #53 having razors would place him at risk of cutting himself or other residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/29/24 at 3:37 PM with LVN G revealed Resident #53 did ask for towels for a shower on 05/28/24. According to LVN G, staff were required to supervise Resident #53 during showers, but he did not like the supervision. According to LVN G, staff were supposed to shave residents and discard the razors after using them. LVN G stated when aides allowed residents to shave themselves it placed the residents at risk of injuring themselves. LVN G stated it was her expectation that staff alerted her if resident had razors in their possession. Observation and interview on 05/31/24 at 11:41 AM revealed ADON B entered Resident #53's room to remove the razors. She talked to him about allowing the staff to shave him or supervise him when he used the razor. ADON B stated Resident #53 told her he got the razors from a facility auction, but ADON B stated that was not true. ADON B stated upon review the razors were similar if not exact to what the facility used to complete shaving residents. According to ADON B, her expectation was that nursing staff observed residents and their rooms, to include removing anything that did not belong. ADON B stated not doing so placed residents at risk of cutting themself, infection, cause harm and prevent safety. Interview on 05/31/24 at 1:30 PM with the DON revealed Resident #53 should not have access to razors. The DON stated she expected staff to pay attention to resident environments, remove things that should not be in their possessions and report their findings. The DON stated nursing staff were to complete or supervise all residents with shaving. The DON stated aides were responsible for ensuring razors were not left with residents, and not doing so placed residents at risk of cutting themselves. Record review of the facility's Accident/Incident Reporting Patient/Resident policy, dated 11/01/17, reflected: The Facility's Leadership will follow the established guidelines for the reporting of accidents and incidents. An incident is any adverse outcome associated as a direct consequence of treatment or care. An accident is an unexpected, unintended event that can result in bodily injury.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent urinary tract infections for one (Resident #97) of three residents reviewed for urinary catheters. The facility failed to contact the physician when Resident #97 had blood in her catheter bag. This failure could affect residents with catheters by placing them at risk for the development and/or worsening of urinary tract infections. Findings included: Review of Resident #97's MDS assessment dated [DATE] revealed the resident was an 89-year- old female admitted to the facility on [DATE]. The resident's diagnosis was acute cystitis without hematuria (infection of the bladder). The MDS also reflected that Resident #97 had an indwelling catheter. Review of Resident #97's undated care plan reflected the resident had an indwelling catheter and recurrent urinary tract infections. Interventions included to assist/provide catheter care as ordered. Care plan also reflected an intervention to use enhanced barrier precautions for residents with catheters to prevent possible infection. Review of Resident #97's progress notes dated 05/25/24 by LVN D revealed that the Foley catheter change was performed and the urinary return was clear and amber in color. Drainage bag was attached and secured below bladder to bed frame. Observation on 05/29/24 at 03:05 PM revealed the resident resting in bed. The Foley catheter bag was hanging below the resident's bladder attached to the bed frame. Observation also revealed the resident's urine in the catheter line was dark red in color. Observation and interview on 05/30/24 at 10:34 AM revealed the resident did not have pain at the time of the interview. Resident #97 also stated she liked the staff, and they were good to her. Interview on 05/29/24 at 3:13 PM with LVN C revealed the resident had hematuria on the 6:00 AM-2:00 PM shift, and it was reported to her on the verbal report during shift change. LVN C stated that there was no charting about Resident #97's hematuria from the previous shift. LVN C stated that she would make the physician aware of resident's urine dark red in color because she could not locate documentation demonstrating that the physician had been notified. LVN C also said that the physician should be notified because urine, dark red in color could indicate a possible urinary tract infection. LVN C also stated the risk of an untreated urinary tract infection was possible sepsis. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/30/2024 at 10:43 AM with CNA B revealed she was not the resident's aide. CNA B stated when she was providing care to residents, she looked for possible signs of urinary tract infections by viewing the Foley bag for dark colored urine and sediment. CNA B stated if she saw these symptoms, she reported them to the charge nurse. The CNA B also revealed a urinary tract infection could lead to worsening confusion and possible falls with injury if left untreated. Interview on 05/30/24 at 10:43 AM with ADON A revealed the signs and symptoms of a urinary tract infection were pain, spiked temperature, dehydration, confusion, and possible blood in the urine. ADON A also stated if a CNA saw any of these signs, they should notify their nurse. ADON A then said the nurse should notify the physician, and the physician would probably order a urinalysis. ADON A stated the risks of an untreated UTI could be that the resident would become septic, or the resident could fall and become injured. Also, ADON A stated blood in the urine meant that the hemoglobin could be affected, and death could result. Interview on 05/30/24 at 3:02 PM with DON revealed the CNA reported there was red urine in the catheter bag at the end of her 6:00 AM-2:00 PM shift on 05/29/24. The DON stated the hematuria was conveyed during verbal report to the oncoming 2:00 PM - 10:00 PM shift nurse. The DON also said the oncoming nurse should call the doctor, family, and flush the line. The DON also revealed the risk to the resident if the hematuria was not treated was that the resident could bleed out, the resident could have an infection, et cetera. And finally, the DON stated if blood was seen in the tubing, it should have been reported immediately to the charge nurse. Record review of the facility's undated policy titled, Catheter - Urinary Catheter, Cleaning and Maintenance: Lippincott Nursing Procedures 9th Ed., pages 432-435 reflected the following: Monitor for changes in urine output, including volume and color. Notify the practitioner of abnormal changes.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings for 1 of 1 resident (Resident #252) reviewed for enteral nutrition. The facility failed to follow Resident #252's physician orders for enteral feeding. These failures could affect residents receiving enteral nutrition/hydration and place them at risk of health complications and decline in health. Findings included: Record review of Resident #252's face sheet dated 05/31/24 revealed the resident was [AGE] year-old male admitted on [DATE] with a diagnosis of gastrostomy status (artificial external opening into the stomach for nutritional support). Record review of Resident #252's admission MDS dated [DATE] revealed the resident had severe cognitive impairment with a BIMS score of 00. The assessment reflected Resident #252 MDS was still in process. Record review of Resident #252's undated care plan revealed the following: Resident #252 was at nutrition and /or dehydration risk; Goal reflected resident will maintain nutritional status as evidenced by no significant weight change; Interventions included monitor weights, skin report, and labs per policy, provide diet as ordered by physician, tube feeding and free water flushes as ordered. Record review of Resident #252's physician orders included the following: *General-dated -05/20/24 - Check blood sugar before meals and at bedtime; 8AM, 1PM, 5PM, 8PM *General-dated -05/20/24 -Enteral feeding; Glucerna 1.5 Flow rate (60/hour) x 20 hours via pump per g-tube. Special instructions: Date, and label tubing with each change. Every shift; First, Second, Third Record review of Resident #252's 05/20/24 - 05/30/24, MAR revealed Resident #252 had been administered Glucerna 1.5. Observation on 05/28/24 at 7:38 PM of Resident #252 revealed him in bed sleeping, Resident had a 3/4 empty bottle of Jevity 1.2 dated 05/27/24. Observation on 05/29/24 at 03:42 PM Resident #252's feeding machine revealed a 3/4 empty bottle of Jevity 1.2 dated 5/29/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 05/29/24 at 4:31 PM with LVN G revealed Resident #252 had a bottle of Jevity 1.2 hung on his machine. LVN G stated resident feeding machine went down at 4 PM; he will resume feeding with this bottle of formula at 8 PM; and his formula bottle would be changed once the bottle was empty. According to LVN G she needed to review physician orders to indicate which formula Resident #252 would be administered. LVN G reviewed the physician orders and revealed Glucerna 1.5 was the appropriate formula to administer to Resident #252. She stated Glucerna was for residents with diabetes which was what Resident #252 was supposed to be administered. LVN G stated resident blood sugar numbers had been ok with no concerns. LVN G stated someone may have grabbed the Jevity 1.5 by mistake. LVN G stated it was the responsibility of the nursing staff to ensure Resident #252 was administered formula according to physician orders. LVN G stated not doing so placed him at risk of his blood sugar readings being abnormal. LVN G stated she had worked on the 2-10 PM since 05/28/24 and did not recognize Resident #252 had been administered the wrong formula and it was her responsibility to review physician orders prior to administering any order. LVN G could not recall how long Resident #252 had been receiving Jevity 1.5 formula. Interview on 05/31/24 at 11:04 AM with ADON B revealed she was not aware Resident #252 was administered Jevity feeding formula. ADON B stated the reason that Resident #252 had the wrong formula was due to the nurse grabbing the wrong formula bottle. ADON B stated Glucerna was more suited for monitoring calorie intakes for people with Diabetes. ADON B stated not following physician orders placed Resident #252 at risk of elevated blood sugar readings. ADON B stated nurses on the floor were responsible for reviewing physician orders and following orders prescribed. ADON B stated if it was not possible to follow those orders the floor nurse should have reported to the physician so an alternate could have been administered and followed up with the Registered Dietician, ADON or DON and family. An attempted interview on 05/31/24 at 11:14 AM with Registered Dietician was unsuccessful. Interview on 05/31/24 at 1:30 PM with DON revealed her expectations were for nursing staff to follow physician orders, should an issue arise nursing staff would report any findings to herself or the ADON's and contact the physician immediately. The DON stated if it was a dietary concern ensure to contact the dietician as well and document. The DON stated if Resident #252's nutrition order was for Glucerna that was what should have been administered. The DON stated not following physician orders for Resident #252 placed him at risk for diarrhea/nausea. The DON stated all charge nurses, ADONs, and myself are all responsible for ensuring physician orders are being followed. Record review of the facility's Physician Orders policy dated 05/05/23, reflected: The qualified licensed nurse will obtain and transcribe orders according to Facility Practice Guidelines. 1. The qualified licensed nurse completes an admission medication regimen review from the transfer record from an acute care hospital, home, or other entity. Refer to the Admission Medication Regimen Review in Pharmacy Services policy and procedure manual. 2. A call is placed to the physician to confirm the orders and request any additional orders as needed (continued on next page)

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	676067	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mira Vista Court	7021 Bryant Irvin Rd Fort Worth, TX 76132

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Enteral and Parenteral Feedings policy, dated 05/05/23, reflected: .2. Obtain a Physician's order for all enteral and parenteral feedings. 3. Communicate orders with Nutrition Services. 4. Notify the facility RD of initial orders to receive enteral and parenteral fluids to secure an assessment of individual patient need. Notify Physician of completed assessment and obtain orders. Orders to include: A. The brand name of the formula B. Strength/concentration C. Rate/frequency/duration of feedings D. Amount and frequency of water to flush the tube. E. Route of administration F. Method of administration of the feeding 5. Monitor and report problems and complications to the Physician and Nutrition Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 of 5 residents (Resident #38) reviewed for medication regimen review. The facility's Pharmacist Consultant recommended Residents #38's anxiety medication hydroxyzine required an additional consent form to be completed and uploaded to the resident's chart. This failure could place residents at risk for possible adverse side effects, adverse consequences, and decreased quality of life. Findings included: Review of Resident #38's Face sheet dated 05/31/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #38's quarterly MDS dated [DATE] revealed he had a BIMS score of 12, indicating no cognitive impairment. Further review revealed she had active diagnoses of Parkinson's disease without dyskinesia, schizoaffective disorder, depressive type, anxiety disorder. Review of Resident #38's care plan undated, revealed the following: *Problem: Resident is receiving antipsychotic medications. Goal: Resident will not exhibit signs of drug related side effect or adverse drug reaction through next review date. Approach: Attempt a gradual dose reduction (if not contraindicated). Pharmacy consultant review. Monitor resident's behavior and response to medications. Review for continued need at least quarterly. *Problem: Resident has a diagnosis of anxiety. Goal: Resident will manage anxiety through effective coping mechanisms and pharmaceutical interventions through next review date. Approach: Administer medications as ordered. Monitor and report for signs and symptoms of adverse reaction to the physician. Review of Resident #38's physician's orders reflected an order for: * Hydroxyzine HCl tablet; 50 mg; Amount to Administer: 2 Tablets; oral; Twice a day; Take at noon and bedtime for anxiety disorder; Start date 08/01/23. *Hydroxyzine HCl tablet; 50 mg; Amount to Administer: 2 Tablets; oral; Twice a day; Take at noon and bedtime for anxiety disorder; Start date 11/08/23. Review of Resident #38's Medication Regimen Review, dated 10/19/23, reflected Please ensure there is an informed consent in resident's chart/profile for the following psychoactive medications: hydroxyzine (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #38's October 2023 MAR reflected Resident #38 received Hydroxyzine HCl tablet; 50 mg the entire month of October 2023. Review of Resident #38's November 2023 MAR reflected Resident #38 received Hydroxyzine HCl tablet; 50 mg; the entire month of November 2023. Review of Resident #38's Medication Regimen Review, dated 12/23/23, reflected Please ensure there is an informed consent in resident's chart/profile for the following psychoactive medications: hydroxyzine Review of Resident #38's December 2023 MAR Resident #38 received Hydroxyzine HCl tablet; 50 mg the entire month of December 2023. Review of Resident #38's Medication Regimen Review, dated 01/16/24, reflected Please ensure there is an informed consent in resident's chart/profile for the following psychoactive medications: hydroxyzine Review of Resident #38's January 2024 MAR reflected Resident #38 received Hydroxyzine HCl tablet; 50 mg; the entire month of January 2024. Review of Resident #38's February 2024 MAR reflected Resident #38 received Hydroxyzine HCl tablet; 50 mg; the entire month of February 2024. Review of Resident #38's March 2024 MAR reflected Hydroxyzine HCl tablet; 50 mg; Amount to Administer: 2 Tablets; oral; Twice a day; Take at noon and bedtime for anxiety disorder was discontinued on 03/01/2024. Interview on 05/31/2023 at 9:35 AM with Resident #38 revealed he could not recall if he signed consent forms for his medications. He denied having any issues with the medications he was currently taking. Interview on 05/31/24 at 11:05 AM with the DON revealed she had been employed since November 2023. The DON stated it was her responsibility to review the pharmacy consultant recommendations and to following up on them and the ADON's also assisted. The DON stated they had completed an audit on pharmacy review and they noticed that consents were missing or not completed. She stated they had to redo all of the resident consent forms. The DON stated Resident #38 consent form was obtained on 02/28/24. Review of Resident #38's informed consent form revealed it was signed on 02/28/24. Review of facility policy entitled Pharmacy Services Policies and Procedures, dated revised 04/17/24, reflected the following: Consultant Pharmacist: The medication regimen of each resident is reviewed by a licensed Pharmacist according to Federal, State, and Local regulations as well as current standards of practice. The pharmacist must report any irregularities to the Attending Physician, the facility's Medical Director and Director of Nursing, and these reports must be acted upon in a manner that meets the needs of the residents.

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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** 48236 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 3 residents (Resident #90) reviewed for medication errors. LVN A failed to order antibiotics and normal saline solution prior to the facility running out, resulting in Resident #90 missing two days of antibiotic therapy. This failure could place residents at risk of their infections worsening and extending their length of stay in the facility. Findings included: Review of Resident #90's admission Record dated 5/30/24 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included osteomyelitis of the vertebrae (infection of the spine), urinary tract infection, and lumbar disc disease. Review of Resident #90's admission MDS, dated [DATE], revealed a BIMS score of 12, indicating she was moderately impaired. Her functional status indicated she required moderate assistance with her ADLs. Review of Resident #90's orders, dated 5/ 31/24, revealed the resident's order was to administer normal saline flush (sodium chloride .9% (flush)) syringe; amount: 10ml; injection every shift first, second, third starting on 4/20/24. Resident's order also revealed to administer ceftriaxone recon solution; 2 grams intravenously once a day at 9:00AM with start date 04/19/24. Review of Resident #90's care plan, dated 04/15/24, revealed she had a self-care deficit related to recent hospitalization due to infections in her spine and urinary tract. Interventions included to monitor urinary and bowel output and assist and provide catheter care as ordered. Also included were to observe level of continence and monitor for decline. Care plan also stated to monitor for complaints of verbal and non-verbal signs of pain during urination. Care plan included to assist with toilet use and provide incontinent care as needed. Care plan stated to perform skin check every shift. Care plan also stated to apply appropriate infection control during care. Also included in care plan was to assist and provide catheter care as ordered. Foley catheter orders stated to change the catheter once a month on the 25th of the month. Orders stated the resident had a 16 french indwelling catheter 10 cc's for a neurogenic bladder and the catheter may be changed for obstruction or dislodging. Included in orders was to change the foley bag as needed. Orders also stated to empty the foley catheter bag every shift and document output. Orders included to document fluid input and output. Review of Resident #90's orders dated 5/31/24, revealed Resident #90 had an order for Review of Resident #90's MAR, undated, revealed Resident #90 missed her dose of antibiotic on 5/18/24 and 5/24/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/30/24 at 01:16 PM Resident #90 revealed she was told once by the day shift M-F charge nurse that she would not be receiving her antibiotic that day. The resident stated that she could not remember the exact date or time. Interview on 05/30/24 at 12:42 PM with LVN A revealed on 05/18/24 Resident #90's Ceftriaxone recon solution, 2 grams, IV, was not in the facility. LVN A stated that she did not work the previous day. LVN A also stated she checked the facility's e-kit, and there was none. LVN A said that she called the pharmacy and placed the order for the medication, and it was delivered that night. LVN A stated she notified the physician that the resident missed the ordered dose and informed the physician the medication had been ordered. The missed dose on 05/24/24 was not given per the MAR because the facility had no normal saline to flush the IV line per the order. LVN A stated it was the nurse's responsibility to ensure that residents' medications are in the building including the normal saline flush so the antibiotic can be administered per the physician's order. LVN A also stated the risk to the resident not receiving their prescribed antibiotics was a possible longer infection time resulting in the resident becoming sicker. LVN A stated the policy stated if the facility does not have a resident's medication, the nurse was to first call the pharmacy to order re-order the medication. Then the nurse should inform the resident's physician, ADON, DON, the resident, and the resident's family. Interview on 05/30/24 at 01:04 PM with ADON A revealed to prevent a dosage of medication from being missed, the nurse should check and medications (including normal saline flush) before it runs out. ADON A also stated agency was often used because there was no full time 2-10 Monday through Friday nurse therefore, agency nurses fail to order medications as instructed per policy. ADON A also revealed there was only one run from pharmacy daily and, if it was ordered after a certain time, it will not be delivered until the following day. ADON A stated t if a resident missed a dosage of a medication, the policy stated the nurse was to notify the physician and follow the physician's orders about the missed dosage. ADON A stated the risk to the resident in missing a dose of an antibiotic was the resident will possibly have the infection longer, possible complications, and possible death. Interview on 05/30/24 at 03:08 PM with DON revealed the order for the missed antibiotic on 05/24/24 was called in to the pharmacy at 8:46 AM on 05/24/24. The DON stated LVN A should have placed the order on hold, contacted the pharmacy, and have the medication sent to the facility stat. The DON also revealed the nurse should notify the physician and family when a medication dosage was missed and then place a note in the EHR stating the same. The DON stated when the antibiotic was received, the nurse should take the order off hold and administer the medication to the resident before notifying the physician. The DON finished by stating the nurse should have notified the ADON and DON (in absence of the DON, the administrator) of a missed medication dosage. The DON stated the missed antibiotic dosage can cause the resident's white blood count to elevate if they don't receive proper treatment. Record review of the facility's Undated policy title, Nursing Policies and Procedures: Medication Management Program reflected the following: If a medication is unavailable, contact the pharmacy and document accordingly. Notify physician for possible alternatives available in e-kits at time of discovery.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44140 Based on observation, interviews and record reviews the facility failed to maintain medical records that were complete and accurately documented for 1 (Resident #15) of 10 residents reviewed for resident records. The facility failed to accurately document Resident #15's use of arm sleeve on 05/28/24, 05/29/24 and 05/30/24 even though it was not performed. These failures could affect any resident, placing them at risk of inaccurate information and resulting inappropriate care. Findings included: Review of Resident #15's Face sheet dated 05/31/24 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #15's quarterly MDS dated [DATE] revealed he had a BIMS score of 09, indicating moderate cognitive impairment. Further review revealed she had active diagnoses of unspecified symbolic dysfunctions, muscle wasting and atrophy, muscle weakness, local infection of the skin and subcutaneous tissue, unspecified. MDS assessment Section M - Skin condition indicated Resident #15 skin intact. Review of Resident #15's care plan revised on 05/20/24 revealed Problem: Resident is a new admission. admitted from THR Downtown Hospital. The resident's Baseline Care Plan will be developed within 48 hours of admission and provided to the resident and legal representative by completion of the comprehensive assessment. Goal: Resident's immediate health and safety needs will be identified. Approach: SKIN INTEGRITY: (X) Treatment- See Physician Orders. Review of Resident #15's physician orders, dated 04/12/24, reflected: Apply arm sleeve to right arm once a day, start time 7:00 AM Record review of Resident #15's May 2024 TAR revealed Resident #15's was provided with her arm sleeve. No indication of refusal was documented. Observation on 05/28/24 at 8:39 PM of Resident #15 in bed with eyes closed. Observed Resident #15 right forearm skin to be dry/flaky rash there was no device (arm sleeve) in place. No open wounds observed. Observation on 05/29/24 at 9:00 AM of Resident #15 in the activity room. Observed Resident #15 in her wheelchair, there was no arm sleeve in place observed to the right arm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 05/29/24 at 12:58 PM of Resident #15 in the dining room. An attempt was made to interview Resident #15; however, she was not a good historian. Observed Resident #15 right forearm skin to be dry/flaky rash there was no arm sleeve in place. Observation 05/30/24 at 8:40 AM of Resident #15 on the hallway. An attempt was made to interview Resident #15; however, she was not a good historian. Observed Resident #15 right forearm skin to be dry/flaky rash there was no arm sleeve in place. Interview on 05/31/24 at 11:47 AM with LVN E revealed she was the nurse for Resident #15. She stated Resident #15 developed a skin rash to the right arm and Resident #15 would scratch herself which cause her to have small scratches. LVN E stated the doctor had ordered for Resident #15 to wear a geri sleeve (arm sleeve) to prevent Resident #15 from scratching her arm. LVN E stated Resident #15 would only allow them to put lotion on and refuses the arm sleeve. LVN E stated she had not attempted to put the arm sleeve today (05/31/24) due to Resident #15 attended activities. LVN E stated Resident #15 had not had the arm sleeve the last few days due to Resident #15 refusing. LVN E stated she had documented incorrectly and should had document refusal. LVN E stated not accurately documenting could affect the way Resident #15 received care. Interview on 05/31/24 at 11:13 AM with the DON revealed Resident #15 had an order for an arm sleeve due to Resident #15 developed a rash on her right arm. The DON stated Resident #15 would refuse the arm sleeve and would take it off. She stated her expectations are for the nurse to follow physician orders and attempt to put the arm sleeve and if refuse nurses should document the refusal. According to the DON by not accurately documenting was considered falsification. Interview on 05/31/24 at 12:28 PM with the ADON revealed Resident #15 had a physician order for a geri sleeve due to Resident #15 developed a skin rash. She stated the geri sleeve was used to protect Resident #15 from scratching. She stated her expectations were for the nurses to follow physician orders. She stated if resident refuses, she expected the nurses to document not administered and to notify the physician of the refusal and discontinue the order. The ADON stated by not documenting accurately led to false documentation. Review of facility policy entitled Nursing Policies and Procedures, dated revised 05/05/23, reflected: Documentation - Licensed Nursing - Medication and Treatments: The qualified nursing staff notes the time, date and dosage of all medications and treatments at the time they are administered and initials the note on the medication and/or treatment record. The nurse's full name and title must be written at least once on each page of the medication/Treatment Record or on an individual resident specific signature sheet. If a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the patient/resident not receiving the medication. The attending physician or physician extender must be notified. Route of administration must be charted.