STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676213	A. Building B. Wing	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hewitt Nursing and Rehabilitation	8836 Mars Dr Hewitt, TX 76643

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure the residents had the right to be free from neglect for one (Resident #1) of five residents reviewed for neglect, in that: The facility failed to administer Resident #1's Levothyroxine (medication used to treat hypothyroidism) for an unknown period of time at the end of June 2024 and beginning of July 2024. This subsequently led to her TSH (Thyroid Stimulating Hormone) levels elevating to 28.62 (normal range is .450 - 5.330), resulting in a change of condition where she became fatigued, dizzy, and depressed. An Immediate Jeopardy (IJ) was identified on 07/24/24 at 4:50 PM. While the IJ was removed on 07/29/24 at 12:15 PM, the facility remained out of compliance at a severity level of no actual harm and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk of not receiving their ordered medications, the loss of the medication's therapeutic benefits, and changes in physical and psychological conditions. 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 hypothyroidism (a condition resulting from decreased production of thyroid hormones) and a history of thyroid cancer resulting in a thyroidectomy (complete or partial removal of the thyroid gland). Review of Resident #1's quarterly MDS assessment, dated 06/22/24, reflected a BIMS score of 15, indicating she was cognitively intact. Review of Resident #1's quarterly care plan, dated 03/26/24, reflected she had hypothyroidism with an intervention of administering thyroid replacement medication which would help restore the level of thyroid hormone produced by the thyroid gland. Review of Resident #1's physician order, dated 02/09/24, reflected Levothyroxine Sodium Oral Tablet - 150 MCG - one time a day for hypothyroidism. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's progress notes, dated 06/28/24 and documented by LVN A, reflected the following: [Resident #1] had c/o nausea with small emesis . [Resident #1] was given Zofran and Tylenol for the headache . Review of Resident #1's progress notes, dated 07/09/24 and documented by LVN A , reflected the following: [Resident #1] notified this nurse and aide that she feels like her mental health is going down. She is requesting to see or speak to someone about it. She stated she just wants to give up . Note left in the social worker's office for eval . Review of Resident #1's psychiatric diagnostic assessment, dated 07/10/24, reflected the following: Reason for referral: depression, withdrawal, appetite disturbance, weight loss, refusal/low motivation to participate in rehab therapy . Review of Resident #1's physician order, dated 06/30/24, reflected Remeron Oral Tablet - 15 MG - give 1 tablet by mouth one time a day for depression. Review of Resident #1's physician order, dated 07/10/24, reflected Sertraline HCl Oral Tablet - 50 MG - give 1 tablet by mouth one time a day for depressive symptoms. Review of Resident #1's lab results, dated 07/15/24, reflected a high level of TSH32 - 28.62 (normal range is . 450 - 5.330). Review of Resident #1's progress notes, dated 07/15/24 and documented by the NP, reflected the following: [Resident #1] needs to be getting her levothyroxine, spoke with ADON concerning this. Re-check TSH in 4 weeks. During a telephone interview on 07/24/24 with Resident #1's RP, she stated toward the end of June (2024), the noticed Resident #1 had a change in condition. She stated she felt weak, terrible, achy, depressed, and like she wanted to die. She stated it affected her enough that she took herself off therapy (psychological) services. She stated although she was now receiving her thyroid medication , she was still not herself as it would take months to get her levels back to normal. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/24/24 at 12:15 PM, Resident #1's PA stated he saw the residents one time a week and the NP saw the residents the other four days but she was on vacation. He stated he was not aware of the situation where Resident #1 went an experienced extended period of time without her thyroid medication. He stated a negative outcome of not being administered thyroid medication when you had been on it for a long period of time and were dependent on it like someone like Resident #1 could be a thyroid crisis, depression, mood problems, and there could be no thyroid hormones in the body which could cause fatigue. He stated he believed her mood could have been affected. He stated after being without the medication for an extended period of time, it could take up to six months to readjust the TSH levels. He stated checking off in the MAR that the Levothyroxine was given when it actually was not would be a huge medication error. During an interview on 07/24/24 at 1:52 PM, Resident #1 stated she had not been aware she was not receiving her thyroid medication but had noticed how much complications it had caused. She stated about three weeks prior to when they realized she had not been receiving the medication (at the beginning of July 2024, she had become really exhausted, was dizzy, had a loss of appetite, and did not even have the energy to go to therapy. She stated she still felt affected by it as she continued to be fatigued and out of it. She stated it has caused her to be scared to trust the nurses to make sure she was receiving her ordered medications. During an interview on 07/24/24 at 2:32 PM, the ADON stated the NP brought to her attention at the beginning of July (2024) that Resident #1's thyroid level was extremely elevated which indicated she had not been receiving her thyroid medications. She stated Resident #1 had been complaining of feeling down, so she looked at everything. She stated when she looked in the medication cart, she found a blister pack with only four missing pills and she could not find the previous blister back from the month prior (June 2024). She stated it was hard to say how many doses she missed but believed it could have been 5-8 doses. She stated not receiving thyroid medication for an extended period of time could lead to someone not feeling good, tired, and weak. She stated the nurse she believed that was not administering the medication (LVN B) no longer worked there. She stated she did conduct a full cart audit on that medication cart but none of the other carts. During an interview on 07/24/24 at 4:32 PM, the DON stated on 07/12/24 the NP notified her that there were only two pills missing from Resident #1's thyroid medication blister pack. She stated the ADON looked into it and they had been delivered on 06/28/24. She stated she believed Resident #1 only could have gone 7-12 days without the medication, but it was not guaranteed. She stated a negative outcome of not receiving the medication for an extended period of time could be feeling tired or depression issues but did not believe that was the case for Resident #1 since it could have only been five days that she had gone without. During a telephone interview on 07/29/24 at 11:58 AM, Resident #1's NP stated Resident #1 had been admitted to the facility over five months ago and she was stable until her depression spiked within the last month. She stated Resident #1 was a good historian and told her at the beginning of July (2024) that for the past few weeks she had been feeling more depressed and felt it getting worse and worse. She stated it was to the point where she did not want to get out of bed. She stated once she ordered lab work and her TSH came back extremely high, it was evident that she had not been receiving her thyroid medication, especially with the symptoms she had been experiencing. She stated she could not put a number on how many doses she could have missed because everyone was different, but it had to have been more than a couple of weeks. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She stated her TSH could be more normalized with in 4-6 weeks. She stated Resident #1 would not be back at her baseline, but on her medication she will have improved drastically. Review of the facility's Abuse and Neglect Policy, Revised December of 2016, reflected the following: Our residents have the right to be free from abuse, neglect . Review of the facility's Administering Medications Policy, revised December of 2012, reflected the following: Medications shall be administered in a safe and timely manner, and as prescribed. . 3. Medications must be administered in accordance with the orders, including any required time frame. The ADM and ADON were notified on 07/24/24 at 4:50 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 07/27/24 at 12:30 PM: Impact Statement: On 7/24/24 an abbreviated survey was initiated, and the facility was provided notification that the Survey Agency has determined that the conditions at the center constitute Immediate Jeopardy to resident health due to not keeping resident free from neglect. How were other residents at risk affected by this deficient practice identified? A. The VP of Clinical in-serviced the DON on audits of thyroid medication orders and the Medication Administration policy and ensuring residents receive their medications on 7/24/24 prior to in servicing staff. B. The facility DON/Designee completed an audit of thyroid medication orders for the residents currently residing in the facility to ensure the residents are receiving their medications. This was completed on 7/24/24. C. An Abuse/Neglect prohibition in-service was conducted by the Administrator with facility staff to include prn staff and newly hired staff on 7/24/24. The facility does not utilize agency. Any staff to include newly hired staff, prn staff not in attendance will be required to receive the in-service prior to working their next scheduled shift. What corrective actions have been implemented for the identified resident? Resident #1 Medication Error report completed, physician and RP notified by the ADON. The DON in-serviced 7/24/24 the licensed nursing staff on Medication Administration. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	What corrective actions were taken? 1. The following actions were initiated immediately on 7/24/24. a. Initiated in-services on 7/24/24 with licensed nurses to include prn staff and newly hired staff by Director of Nursing on Administering Medications and ensuring residents receive their medications during the hour before to hour after time frame. Newly hired licensed nurses and medication aides, prn staff will be in serviced during the on boarding process by DON/designee on Medication Administration policy. The DON/designee will complete Medication Pass Observations during orientation utilizing the medication pass observation tool. If licensed nurses or medication aides pass, competency will be demonstrated. If licensed nurses or medication aides fail, DON/Designee will retrain with return demonstration; and another Medication Pass Observation will be conducted until competency demonstrated. The facility does not utilize agency. DON/designee will conduct randomized MAR to card audits three times a week for 4 weeks, and then periodically to assure residents are getting medications. 2. The VP of Clinical in-serviced the DON on the Medication Administration policy and ensuring residents receive their medications on 7/24/24. b. On 7/24/24 the DON initiated in-services for the Medication Aides on Administering Medications and ensuring residents receive their medications during the hour before to hour after time frame. The DON/Designee will complete Medication Pass Observations with the licensed nurses and Medication Aides utilizing the medication pass observation tool. If licensed nurses or medication aides pass, competency will be demonstrated. If licensed nurses or medication aides fail, DON/Designee will retrain with return demonstration; and another Medication Pass Observation will be conducted until competency demonstrated. Random Med Pass Observations will be conducted weekly x 4 weeks with the licensed nurses and medication aides to ensure the medication administration policy is followed and that residents are receiving their medication as ordered. If discrepancies are identified, they will be addressed immediately by the DON or ADON. Starting on 7/24/24 DON/designee will conduct randomized MAR to card audits three times a week for 4 weeks, and then periodically to assure residents are getting medications. 3. Newly hired licensed nurses and medication aides, prn staff and agency staff will be in serviced during the on boarding process by DON/designee on Medication Administration policy. The DON/designee will complete Medication Pass Observations during orientation utilizing the medication pass observation tool. If licensed nurses or medication aides pass, competency will be demonstrated. If licensed nurses or medication aides fail, DON/Designee will retrain with return demonstration; and another Medication Pass Observation will be conducted until competency demonstrated. 4. The DON/Designee will complete Medication Pass Observations with the licensed nurses and Medication Aides utilizing the medication pass observation tool. If licensed nurses or medication aides pass, competency will be demonstrated. If licensed nurses or medication aides fail, DON/Designee will retrain with return demonstration; and another Medication Pass Observation will be conducted until competency demonstrated. Random Med Pass Observations will be conducted ongoing weekly with the licensed nurses and medication aides to ensure the medication administration policy is followed and that residents are receiving their medication as ordered. If discrepancies are identified, they will be addressed immediately by the DON or ADON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. On 7/24/24 the DON/Designee initiated in-services with licensed nurses and medication aides, on Abuse and Neglect Policy and Procedures with a pre and posttest attached; competency demonstrated as seen by test results. 6. On 7/24/24 the Administrator/Designee initiated life satisfactions surveys with no concerns noted. 7. How will the system be monitored to ensure compliance? A. DON/Administrator will review the results of the Medication Pass Observations that will be completed for the next six weeks. If discrepancies are identified, they will be addressed immediately, and physician notified. Staff will receive further training on our Medication Administration Policy and disciplinary action up to termination. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 7/24/24 with the Medical Director. The Medical Director has reviewed and agrees with this plan of removal. This plan will be monitored monthly during Quality Assurance and Performance Improvement meetings ongoing for any further education identified. The Surveyor monitored the POR on 07/28/24 as followed: During interviews on 07/28/24 from 11:42 AM - 2:32 PM with one RN, three LVNs, two MAs, and three CNAs from different shifts, all stated they were in-serviced before their shift. They all knew who the Abuse and Neglect Coordinator was (the ADM) and gave examples of abuse and neglect such as not changing a resident's brief in a timely manner, verbal, physical, psychosocial, and mental abuse. All stated they would never check off a MAR if they did not administer the medication. All stated the importance of residents receiving their ordered medications. Review of an in-service entitled Medication Administration, dated 07/24/24 and conducted by the VPCS, reflected the DON was reeducated on their Medication Administration policy. Review of in-services entitled Abuse and Neglect, dated 07/24/24 and 07/25/24 and conducted by the ADM, reflected all nursing staff were reeducated on the facility's Abuse and Neglect policy. Review of Abuse and Neglect Post Test Competencies, dated 07/24/24 and 07/25/24, reflected all staff took a post-test after being in-serviced and passed. Review of Life Satisfaction Surveys, dated 07/26/24, reflected all residents were interviewed with no concerns. Review of in-services entitled Medication Administration, dated 07/24/24 and 07/25/24 and conducted by the DON, reflected nurses and medication aides were reeducated on checking the MAR throughout shift for any medications due and checking the MAR/TAR at the end of the shift for any omissions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Medication MAR to Card Audit, on 7/26/24, reflected the medication carts (four) had been audited on 07/24/24 and 07/25/24 to match the MAR to the medication cards. Review of Medication Pass Observations, dated 07/24/24 - 07/26/24, reflected nurses and medication aides had to conduct a medication pass check-off. While the IJ was removed on 07/29/24 at 12:15 PM, the facility remained out of compliance at a severity level of no actual harm and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42949 Based on interview and record review the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections to the extent possible for three (Resident #1, Resident #2, and Resident #3) of six residents reviewed for incontinent care. The facility failed to: 1. Change Resident #1's foley catheter after she was diagnosed with a UTI until six days later and failed to ensure the catheter bag was not continuously laying on the ground on 07/24/24. 2. Ensure Resident #2 was provided incontinent care after CNAs E and F removed her dirty brief and put on a clean one. 3. Ensure sanitary infection control practices were used when CNA G provided incontinent care to Resident #3. CNA G also failed to don PPE per EBP protocol as Resident #3 had an indwelling catheter. These failures placed residents at risk of transmission and/or spread of infection or contagious disease which could lead to further infections and hospitalization . Findings included: 1. 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, hemiplegia (one-sided paralysis), retention of urine, and type II diabetes. Review of Resident #1's quarterly MDS assessment, dated 06/22/24, reflected a BIMS score of 15, indicating she was cognitively intact. Section H (Bladder and Bowel) reflected she had an indwelling catheter. Review of Resident #1's quarterly care plan, dated 03/26/24, reflected she had the inability to control urination and is incontinent with an intervention of observing/reporting to MD and any s/sx of UTI. Review of Resident #1's physician order, dated 07/21/24, reflected Foley Catheter 18 FR 10cc bulb to bedside drainage. Review of Resident #1's progress notes, dated 06/28/24 and documented by the NP, reflected the following: Family requesting UA due to cloudy urine with sediment , nausea, and vomiting . Resident #1 started antibiotics (Cefdinir) on 07/01/24 for a UTI for seven days. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's physician order, dated 05/30/24, reflected Change Foley Catheter PRN for s/s of infection, obstruction or if closed system is compromised. Review of Resident #1's TAR, July 2024, reflected her foley catheter was changed on 07/07/24 . Observation on 07/24/24 at 12:15 PM revealed Resident #1's foley drainage bag lying flat on the ground under her bed. Observation on 07/24/24 at 12:50 PM revealed Resident #1's foley drainage bag lying flat on the ground under her bed. Observation on 07/24/24 at 1:52 PM revealed Resident #1's foley drainage bag lying flat on the ground under her bed. Observation on 07/24/24 at 3:06 PM revealed Resident #1's foley drainage bag lying flat on the ground under her bed. During a telephone interview on 07/24/24 at 10:28 AM, Resident #1's RP stated she noticed at the end of June (2024), that Resident #1's catheter bag looked yucky and she requested they check for a UTI. She stated she did end up having a UTI and was treated with antibiotics. She stated on 07/06/24 she noticed it was the same catheter and the tubing was full of sediment. She stated she asked for the nurse to put a fresh one in. She stated the nurse tried to flush the tubing and it was so clogged she was not able to. She stated she told the NP who elevated the concern to the ADON. She stated she was a nurse and knew that if someone tested positive for a UTI the catheter needed to be changed to ensure there was no more bacteria. 2. Review of Resident #2's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including type II diabetes, chronic kidney disease, age-related physical debility, and morbid obesity. Review of Resident #2's quarterly MDS assessment, dated 06/27/24, reflected a BIMS score of 7, indicating a severe cognitive impairment. Section GG (Functional Abilities and Goals) reflected she was dependent on staff with toileting. Section H (Bladder and Bowel) reflected she was always incontinent of bladder and bowel. Review of Resident #2's quarterly care plan, dated 07/10/24, reflected she was incontinent of bowel and bladder with an intervention of providing prompt incontinent care. Review of video footage of Resident #2, dated 07/18/24 and provided by Resident #2's FM C, revealed CNAs E and F in Resident #2's room about to provide incontinent care. CNAs E and F were both wearing gloves that were not changed during the duration of the footage. CNA E opened the brief then they rolled Resident #2 on her left side and removed the brief and placed it on the floor. Without utilizing wipes or providing any incontinent care, a clean brief was placed on Resident #2. CNA F picked up the dirty brief and bed pad off the floor and used her dirty gloves to open the blinds before leaving the room. CNA E used her dirty gloves to pull Resident #2's blankets up and on top of her. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #3's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including acute kidney failure, type II Diabetes, lumbago (lower back pain), and muscle weakness. Review of Resident #3's admission MDS assessment, dated 07/04/24, reflected a BIMS score of 13, indicating a intact cognition. Section GG (Functional Abilities and Goals) reflected she required substantial/maximal assistance with toileting. Section H (Bowel and Bladder) reflected she had an indwelling catheter. Review of Resident #3's admission care plan, dated 07/02/24, reflected no focus areas related to her catheter or ADL assistance. Review of Resident #3's physician order, dated 07/02/24, reflected Foley catheter care Q shift and PRN. During an observation on 07/24/24 at 11:59 AM revealed CNA G performing peri and catheter care on Resident #3. There was not a sign on the door indicating any EBP precautions were required nor was there a PPE cart near the doorway. CNA G told Resident #3 what she was going to do, then went to the bathroom and washed her hands, and donned gloves. She did not don a gown or mask per EBP precautions. She removed the front of the brief which revealed an indwelling catheter was present. CNA G removed one wipe from the package and swiped three areas at the front of the perineum with the same wipe and then threw it away. She grabbed another wipe from the package and swiped the labia twice with the same wipe and threw it away. She then picked up a trash can and placed it closer to her work area. Without changing gloves or performing hand hygiene, she took a wipe from the package and cleaned the indwelling catheter. CNA G repositioned Resident #13 on her right side, removed the soiled brief, and placed it in the trash can. She took a wipe from the package, swiped between the buttocks then folded the stool-soiled wipe and swiped again. She then took two wipes from the package, swiped, folded, and swiped between the buttocks again. She then removed another wipe from the package, swiped between the buttocks, folded the wipe, swiped between the buttocks, then folded the wipe again and swiped a third time. She then doffed soiled gloves, performed hand hygiene, and applied a clean brief. During an interview on 07/24/24 at 12:05 PM, CNA G stated she had recently been in-serviced on infection control. CNA G stated they used EBP for residents with feeding tubes or IV's but not for catheters. She stated if a resident was on precautions, there should be a PPE cart near the door. She stated when she was trained on peri care, they used wash clothes instead of disposable wipes. She stated she figured it was okay to use a couple of wipes at a time so it was thicker (like a washcloth) and then she could fold the wipe and use it more than once. She stated she had never heard of one wipe, one swipe when in-serviced on peri care. During an interview on 07/24/24 at 12:15 PM, the PA stated when performing incontinent care, he expected for the peri area to be cleaned thoroughly. He stated if it was not, it could lead to skin and yeast infections. He stated when going from dirty to clean during peri care changing gloves was best practice . He stated any infection control issues during peri care could increase UTI's. He stated when a resident tested positive for a UTI, the foley catheter should be changed to prevent the reoccurrence of a UTI. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hewitt Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8836 Mars Dr Hewitt, TX 76643	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/24 at 2:23 PM, the ADON stated a resident should be on EBP precautions (with a sign on their door) when they had a foley catheter, g-tube, or IV. She stated when performing care, staff should be donning a gown, mask, and gloves. She stated a negative outcome of not donning PPE would be the risk of infection and the staff needed to protect themselves as much as they were protecting the residents. She stated the same wipe should never be used more than once during peri care to prevent infection. During an interview on 07/24/24 at 4:23 PM, she DON stated residents with catheters, g-tubes, or IVs should be on EBP when providing care and staff should be donning the proper PPE for infection control. She stated a resident's catheter should only be changed after being diagnosed with a UTI if there was sediment present or if the urine was cloudy. During a telephone interview on 07/29/24 at 11:58 AM, the NP stated if a resident tested positive for a UTI, the catheter must be changed because the bacteria that caused the UTI would still be in there. She stated she was not aware she needed to write an order for that as it was normally facility protocol. She stated a catheter bag should never be left on the ground to prevent contamination or infection. She stated appropriate infection control procedures were important during peri care as it was an easy way to spread infection. She stated it would be unacceptable to use a wipe to swipe more than one time during peri care and would assume staff would be changing clothes gloves between going from dirty to clean. Review of the facility's Infection Control Policy, revised July of 2014, reflected the following: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Review of the facility's Catheter Care Policy, Revised April of 2010, reflected the following: .b. Be sure the catheter tubing and drainage bag are kept off the floor. .Changing Catheters 1. Changing indwelling catheters: It's recommended to change indwelling catheters and bedside drainage bags as needed for clinical indications such as infection, obstruction, or when closed system is compromised. Review of the facility's Perineal Care Policy, revised December 2011, reflected the following: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Steps in the Procedure: . Do not reuse the same disposable wipe/washcloth or water to clean the urethra or labia. Review of the facility's Enhanced Barrier Precautions Policy, dated 04/01/24, reflected the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This policy outlines the guidelines and procedures to implement enhanced barrier precautions to prevent the spread of infectious diseases among residents and staff. 'Enhanced Barrier Precautions' (EBP) refers to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety 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** 42949 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of five residents reviewed for pharmacy services. The facility failed to administer Resident #1's Levothyroxine (medication used to treat hypothyroidism) for an unknown period of time at the end of June 2024 and beginning of July 2024. This subsequently led to her TSH (Thyroid Stimulating Hormone) levels elevating to 28.62 (normal range is .450 - 5.330), resulting in a change of condition where she became fatigued, dizzy, and depressed. An Immediate Jeopardy (IJ) was identified on 07/24/24 at 4:50 PM. While the IJ was removed on 07/29/24 at 12:15 PM, the facility remained out of compliance at a severity level of no actual harm and at a scope of pattern 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 hypothyroidism (a condition resulting from decreased production of thyroid hormones) and a history of thyroid cancer resulting in a thyroidectomy (complete or partial removal of the thyroid gland). Review of Resident #1's quarterly MDS assessment, dated 06/22/24, reflected a BIMS of 15, indicating she was cognitively intact. Review of Resident #1's quarterly care plan, dated 03/26/24, reflected she had hypothyroidism with an intervention of administering thyroid replacement medication which would help restore the level of thyroid hormone produced by the thyroid gland. Review of Resident #1's physician order, dated 02/09/24, reflected Levothyroxine Sodium Oral Tablet - 150 MCG - one time a day for hypothyroidism. Review of Resident #1's progress notes, dated 06/28/24 and documented by LVN A, reflected the following: [Resident #1] had c/o nausea with small emesis . [Resident #1] was given Zofran and Tylenol for the headache . (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's progress notes, dated 07/09/24 and documented by LVN A, reflected the following: [Resident #1] notified this nurse and aide that she feels like her mental health is going down. She is requesting to see or speak to someone about it. She stated she just wants to give up . Note left in the social worker's office for eval . Review of Resident #1's psychiatric diagnostic assessment, dated 07/10/24, reflected the following: Reason for referral: depression, withdrawal, appetite disturbance, weight loss, refusal/low motivation to participate in rehab therapy . Review of Resident #1's physician order, dated 06/30/24, reflected Remeron Oral Tablet - 15 MG - give 1 tablet by mouth one time a day for depression. Review of Resident #1's physician order, dated 07/10/24, reflected Sertraline HCl Oral Tablet - 50 MG - give 1 tablet by mouth one time a day for depressive symptoms. Review of Resident #1's lab results, dated 07/15/24, reflected a high level of TSH32 - 28.62 (normal range is . 450 - 5.330). Review of Resident #1's progress notes, dated 07/15/24 and documented by the NP, reflected the following: [Resident #1] needs to be getting her levothyroxine, spoke with ADON concerning this. Re-check TSH in 4 weeks. During a telephone interview on 07/24/24 with Resident #1's RP, she toward the end of June (2024), the noticed Resident #1 had a change in condition. She stated she felt weak, terrible, achy, depressed, and like she wanted to die. She stated it affected her enough that she took herself off therapy services. She stated although she was now receiving her thyroid medication , she was still not herself as it would take months to get her levels back to normal. During an interview on 07/24/24 at 12:15 PM, Resident #1's PA stated he saw the residents one time a week and the NP saw the residents the other four days but she was on vacation. He stated he was not aware of the situation where Resident #1 went an extendedperienced period of time without her thyroid medication. He stated a negative outcome of not being administered thyroid medication when you had been on it for a long period of time and were dependent on it like someone like Resident #1 could be a thyroid crisis, depression, mood problems, and there could be no thyroid hormones in the body which could cause fatigue. He stated he believed her mood could have been affected. He stated after being without the medication for an extended period of time, it could take up to six months to readjust the TSH levels. He stated checking off in the MAR that it was given when it actually was not would be a huge medication error. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/24/24 at 1:52 PM, Resident #1 stated she had not been aware she was not receiving her thyroid medication but had noticed how much complications it had caused. She stated about three weeks prior to when they realized she had not been receiving the medication, she had become really exhausted, was dizzy, had a lost of appetite, and did not even have the energy to go to therapy. She stated she still felt affected by it as she continued to be fatigued and out of it. She stated it has caused her to be scared to trust the nurses to make sure she was receiving her ordered medications. During an interview on 07/24/24 at 2:32 PM, the ADON stated the NP brought to her attention that Resident #1's thyroid level was extremely elevated which indicated she had not been receiving her thyroid medications . She stated Resident #1 had been complaining of feeling down, so she looked at everything. She stated when she looked in the medication cart, she found a blister pack with only four missing pills and she could not find the previous blister back from the month prior (June 2024). She stated it was hard to say how many doses she missed but believed it could have been 5-8 doses. She stated not receiving thyroid medication for an extended period time could lead to someone not feeling good, tired, and weak. She stated the nurse she believed that was not administering the medication (LVN B) no longer worked there. She stated she did conduct a full cart audit on that medication cart but none of the other carts. During an interview on 07/24/24 at 4:32 PM, the DON stated on 07/12/24 the NP notified her that there were only two pills missing from Resident #1's thyroid medication blister pack. She stated the ADON looked into it and they had been delivered on 06/28/24. She stated she believed Resident #1 only could have gone 7-12 days without the medication, but it was not guaranteed. She stated a negative outcome of not receiving the medication for an extended period of time could be feeling tired or depression issues but did not believe that was the case for Resident #1 since it could have only been five days that she had gone without. During a telephone interview on 07/29/24 at 11:58 AM, Resident #1's NP stated Resident #1 had been admitted to the facility over five months ago and she was stable until her depression spiked within the last month. She stated Resident #1 was a good historian and told her at the beginning of July (2024) that for the past few weeks she had been feeling more depressed and felt it getting worse and worse. She stated it was to the point where she did not want to get out of bed. She stated once she ordered lab work and her TSH came back extremely high, it was evident that she had not been receiving her thyroid medication, especially with the symptoms she had been experiencing. She stated she could not put a number on how many doses she could have missed because everyone was different, but it had to have been more than a couple of weeks. She stated her TSH could be more normalized with 4-6 weeks. She stated Resident #1 would not be back at her baseline, but on her medication she will have improved drastically. Review of the facility's Administering Medications Policy, revised December of 2012, reflected the following: Medications shall be administered in a safe and timely manner, and as prescribed. . (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Medications must be administered in accordance with the orders, including any required time frame. Review of the Mayo Clinic website, accessed 08/12/24, hypothyroidism that is not treated can lead to goiter (a condition that may cause problems with swallowing or breathing), heart disease and heart failure, and peripheral neuropathy (nerve damage causing pain, numbness, and tingling in the arms and legs). The ADM and ADON were notified on 07/24/24 at 4:50 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 07/27/24 at 12:30 PM: Impact Statement: On 7/24/24 an abbreviated survey was initiated, and the facility was provided notification that the Survey Agency has determined that the conditions at the center constitute Immediate Jeopardy to resident health due to not providing pharmaceutical services to meet the needs of a resident. How were other residents at risk affected by this deficient practice identified? D. The VP of Clinical in-serviced the DON on completing an audit on thyroid medication orders and the Medication Administration policy and ensuring residents receive their medications on 7/24/24, prior to in-servicing staff. B. The facility DON/Designee completed an audit of thyroid medication orders for the residents currently residing in the facility to ensure the residents are receiving their medications. This was completed on 7/24/24. What corrective actions have been implemented for the identified resident? Resident #1 Medication Error report completed physician and RP notified by the ADON. Order to recheck thyroid lab on 8/16/24 received. Don/Designee will ensure new order is completed. The DON in-serviced 7/24/24 the licensed nursing staff on Medication Administration. What corrective actions were taken? 8. The following actions were initiated immediately on 7/24/24. c. Initiated in-services on 7/24/24 with licensed nurses by Director of Nursing on Administering Medications and ensuring residents receive their medications during the one hour before and one hour after time frame. Licenses nurses vocalized understanding and signed in-service as confirmation of education and competency. Starting on 7/24/24, DON/designee will conduct randomized MAR to card audits three times a week for 4 weeks, and then periodically to assure residents are getting medications. d. On 7/24/24 The VP of Clinical in serviced the DON on Administering Medications and ensuring residents receive their medications prior to in-servicing staff. (continued on next page)

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F 0755

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

e. On 7/24/24 the DON initiated in-services for the Medication Aides on Administering Medications and ensuring residents receive their medications during the one hour before and one hour after time frame. Medication Aides vocalized understanding and signed in-service as confirmation of education and competency. The understanding verification will be completed and documented using a Medication Administration Competency skill check list.

f. Newly hired licensed nurses and medication aides will be in serviced during the on boarding process by DON/designee on Medication Administration policy. Licenses nurses and medication aides will vocalize understanding and signed in-service as confirmation of education and competency. The DON/designee will complete a Medication Pass Observation on a competency skill list document during orientation. VP of clinical trained DON on medication administration policy prior to DON in-servicing staff on 7/24/24.

g. Starting on 7/25/24 the DON/Designee will complete Medication Pass Observations with the licensed nurses and Medication Aides for four weeks. Random Med Pass Observations will be conducted weekly ongoing thereafter with the licensed nurses and medication aides to ensure the medication administration policy is followed and that residents are receiving their medication as ordered. If discrepancies are identified, the DON and/or ADON will address immediately.

9. How will the system be monitored to ensure compliance?

B. DON/Administrator will review the results of the Medication Pass Observations that will be completed for the next four weeks. If discrepancies are identified, they will be addressed immediately, and physician notified. Staff will receive further training on our Medication Administration Policy and disciplinary action up to termination.

Quality Assurance

An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 7/24/24 with the Medical Director. The Medical Director has reviewed and agrees with this plan of removal.

This plan will be monitored monthly during Quality Assurance and Performance Improvement meetings ongoing for any further education identified.

The Surveyor monitored the POR as followed:

During interviews on 07/28/24 from 11:42 AM - 2:32 PM with one RN, three LVNs, two MAs, and three CNAs from different shifts, all stated they were in-serviced before their shift. All stated they would never check off a MAR if they did not administer the medication. All stated the importance of residents receiving their ordered medications.

Review of an in-serviced entitled Medication Administration, dated 07/24/24 and conducted by the VPCS, reflected the DON was reeducated on their Medication Administration policy.

Review of in-services entitled Medication Administration, dated 07/24/25 and 07/25/24 and conducted by the DON, reflected nurses and medication aides were reeducated on checking the MAR throughout shift for any medications due and checking the MAR/TAR at the end of the shift for any omissions.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Medication MAR to Card Audit, on 7/26/24, reflected the medication carts (four) had been audited on 07/24/24 and 07/25/24 to match the MAR to the medication cards. Review of Medication Pass Observations, dated 07/24/24 - 07/26/24, reflected nurses and medication aides had to conduct a medication pass check-off. An Immediate Jeopardy (IJ) was identified on 07/24/24 at 4:50 PM. While the IJ was removed on 07/29/24 at 12:15 PM, the facility remained out of compliance at a severity level of no actual harm and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview and record review, the facility failed to obtain laboratory services to meet the needs of its residents for one (Resident #2) of five residents reviewed for laboratory services. The facility failed to collect a urine specimen for a UA (urine analysis) for Resident #2 as ordered by the physician on 07/19/24 until 07/24/24 because they were out of UA specimen collection cups. Resident #2 was diagnosed with a UTI on 07/28/24 which required antibiotics for seven days. This failure could place residents with indwelling urinary catheters at risk of infection, renal failure, urinary tract infections, and pain. Findings Included: Review of Resident #2's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including type II diabetes, chronic kidney disease, age-related physical debility, and morbid obesity. Review of Resident #2's quarterly MDS assessment, dated 06/27/24, reflected a BIMS of 7, indicating a severe cognitive impairment. Section H (Bladder and Bowel) reflected she was always incontinent of bladder. Review of Resident #2's quarterly care plan, dated 07/10/24, reflected she was incontinent of bowel and bladder with an intervention of providing prompt incontinent care. Review of Resident #2's physician order , dated 07/19/24, reflected a STAT UA. Review of Resident #2's physician order, dated 07/22/24, reflected a UA and C&S for UTI. Review of Resident #2's physician order, dated 07/24/24, reflected a UA and C&S for UTI. Review of Resident #2's MAR, July 2024, reflected a urine sample had not been collected for a UA until 07/24/24. Review of Resident #2's physician order, dated 07/28/24, reflected Ciprofloxacin HCl Tablet - 500 MG - Give 1 tablet by mouth every 12 hours for UTI for 7 days. During an interview on 07/24/24 at 12:15 PM, Resident #2's PA stated he saw the residents once a week while the NP saw them the rest of the week. He stated he had not known a UA was ordered for Resident #1 nor that the facility staff had not collected a urine sample. He stated his expectations were if a UA was ordered by either him or the NP that a urine sample be collected the same day for testing. He stated symptoms of a UTI could exacerbate if not caught and treated in an appropriate timeframe. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/24 at 2:00 PM, the DON stated they had not received the results of Resident #2's UA from 7/19/24 yet. She then stated Resident #2 was incontinent and the staffthey tried to utilize an in-and-out catheter but there had been no specimen to collect because she had already been incontinent. She stated that was why another order had been written. During an observation and interview on 07/24/24 at 2:05 PM, revealed Resident #2 in her room with FM C and FM D eating food they had brought in for her. FM C stated Resident #2's increased confusion had gotten worse the week prior and that was when she started asking for a UA because something had changed. FM C stated she visited Resident #2 over the weekend (07/20/24 - 07/21/24) and asked staff multiple times about getting the specimen and kept being told, Someone is coming to get it but no one ever came. During an interview on 07/24/24 at 2:32 PM, the ADON stated a UA was ordered for Resident #2 on 07/19/24 due to increased confusion. She stated she did not find out until earlier that week (07/22/24) that they were out of UA specimen collection cups and that was why it had not been collected over the weekend. She stated no one told her they were out over the weekend. She stated she then started calling around looking for some. She stated her expectation was that a urine specimen be collected the same day it was ordered. She stated if a resident was symptomatic for a UTI it could lead to a bad infection. During an observation and interview on 07/24/24 at 3:00 PM, revealed the cabinet where the UA specimen cups were stored was empty. The ADON confirmed that was where the cups were normally stored but they were out. The DON joined the conversation and stated they were not out of specimen cups. The ADON stated they had been out for several days but had recently been informed some had been delivered. During a telephone interview on 07/29/24 at 11:58 AM, Resident #2's NP stated she ordered the STAT UA on 07/19/24 due to Resident #2's increased confusion and altered mental status. She stated she was not aware the specimen was not collected until today as she was on vacation last week. She stated it was her expectation that a sample be collected and sent to the lab no longer than six hours after the order is made. She stated going five days without collecting the specimen for testing after being ordered was unacceptable. Review of the facility's Lab and Diagnostic Test Results Policy, revised April 2007, reflected the following: 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests.