

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Five Points Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1625 Point West Parkway Amarillo, TX 79124	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491</p> <p>Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 1 (Resident #72) of 19 residents reviewed for DNR orders.</p> <p>Resident #72 had a Full Code Status in active medical orders and on Resident's Face Sheet as well as a Do Not Resuscitate (DNR) form in her health record.</p> <p>This failure could place residents at risk of having their end of life wishes dishonored.</p> <p>Findings:</p> <p>Record review of the face sheet for Resident #72 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of unspecified intracapsular fracture of right femur (upper leg bone), subsequent encounter for closed fracture with routine healing (break within the hip joint capsule), Alzheimer's disease (memory loss) with late onset, unspecified osteoarthritis (break down of joints causing pain related to age/wear and tear), unspecified site. The Advance Directive tab on the Face Sheet documented Resident #72 as a Full Code (a patient's request to receive all possible medical interventions, including CPR, in the event of a cardiac or respiratory arrest).</p> <p>Record review of the Admission MDS dated [DATE] for Resident #72 revealed a BIMS score of 0 out of 15 indicating her cognition was severely impaired.</p> <p>Record review of Resident #72's Electronic Health Record under the miscellaneous tab contained a Do Not Resuscitate form signed by family, 2 witnesses, and physician.</p> <p>Record review of Resident #72's care plan dated [DATE] documented Resident #72 as DNR.</p> <p>Record review of Resident #72's Active Orders as of [DATE] revealed an active order for Full Code dated [DATE].</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 8:45 AM, the ADON stated that the nursing staff is responsible for putting the code status of the resident in the electronic health record and the nursing staff are supposed to check the next day after admission to make sure the code status was put in correctly. The ADON was shown the Orders and Face Sheet for Resident #72 which revealed the resident was a Full Code, and then was shown the DNR and Care plan which showed Resident #72 was a DNR. The ADON stated this was inaccuracy of records and the negative outcome for inaccuracy for code status for a resident could be that they could perform CPR on someone who would not want to be resuscitated.</p> <p>During an interview on [DATE] at 9:04 AM, LVN F stated he had worked in the facility for 3 ,d+[DATE] years. He confirmed he was the nurse working on the hallway Resident #72 was currently residing on. LVN F stated that if he had a resident who coded (someone who has experienced a cardiac or respiratory arrest, triggering a code blue or similar emergency response, and requiring immediate life-saving measures) on his shift, he would check their chart under code status and if they were a full code, he would send someone to get the crash cart (a wheeled cart stocked with emergency medical equipment, supplies, and drugs, primarily used during medical emergencies, especially for cardiac arrest resuscitation efforts) and start CPR immediately and then call 911. LVN F stated if a resident had CPR performed on them, but they were a DNR, that would be a huge problem. He stated the negative outcome for performing CPR on a resident who had a DNR could be cracking ribs and possibly killing them.</p> <p>During an interview on [DATE] at 9:07 AM, the DON was shown the Face Sheet for Resident #72 being a Full Code and the resident's DNR. The DON stated that it was an inaccuracy of resident records and that a negative outcome for this could be that someone could possibly not see the DNR and perform CPR, which could upset the family because their wishes were not followed. The DON stated that it was the nurse's responsibility to put in code statuses for residents.</p> <p>During an interview on [DATE] at 10:02 AM, the DON stated that they do not have a policy regarding accuracy of records.</p> <p>Record review of facility policy titled, Physician's Orders and dated 2015 revealed:</p> <p>Purpose: To monitor and ensure the accuracy and completeness of all physician orders.</p> <p>1. Physician's monthly consolidated orders must be reviewed by a licensed nurse to assure they reflect all current orders.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>39813</p> <p>Based on observation, interview, and record review the facility failed to ensure residents have the right to personal privacy and confidentiality of his or her personal and medical records for 1 of 4 hallways (Hall 100) that were monitored for personal privacy.</p> <p>A resident information sheet was left in the family area of hallway 100 for a 2-hour period.</p> <p>This failure has the potential to affect residents receiving care in the facility by exposing their personal medical information.</p> <p>Finding include:</p> <p>During an observation on 03/24/25 at 10:00 AM a CNA assignment sheet dated 03/19/25 was observed on a round brown table with 4 chairs at the end of the 100 Hall. Also noted in the room were two large chairs for visitors and the room was labeled as the Living Room. The room was open to the 100 Hall with no doors present. The CNA assignment sheet contained 16 resident's names with the following:</p> <p>16 Residents had their primary diagnoses listed.</p> <p>16 Residents were listed with dietary needs from mechanical soft diet to regular diet.</p> <p>16 Residents were listed as a DNR or a Full Code for their Advanced Directive.</p> <p>14 Resident were listed as incontinent or continent.</p> <p>11 Residents had their vital signs listed.</p> <p>No staff were present. Two residents were in the hallway within eyesight of the table.</p> <p>During an observation on 03/24/25 at 10:59 AM the same CNA assignment sheet dated 03/19/25 was observed on the round brown table at the end of the 100 Hall. No staff were present.</p> <p>During an observation on 03/24/25 at 12:12 PM the same CNA assignment sheet dated 03/19/25 was observed on the round brown table at the end of the 100 Hall. No staff were present.</p> <p>During an interview on 03/25/25 at 08:48 AM CNA G (assisting with 100 Hall care this shift) reported that resident information should be stored in a way that maintains privacy. CNA G said that resident information should not be stored where someone could see it because that could be a HIPAA violation. CNA G reported that if a resident's information was left out then someone could steal it. CNA G denied that she was the staff member that left the CNA assignment sheet at the end of the 100 Hall.</p> <p>(continued on next page)</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/25/25 at 09:54 AM LVN C reported that a resident's information should be private and covered. LVN C said that if a resident's information was left out and could be accessed it would violate the residents' rights and that is why it should be kept private so no one can access it. LVN C reported that if a resident's information was left out then anyone could read it and they could give that information to other people. A family member could be in the hallway and could read the residents information and could give that information to someone else. LVN C reported that violating a resident's private information could lead to a resident feeling disappointed, upset, and embarrassed.</p> <p>During an interview on 03/26/25 at 10:22 AM the DON reported that the open areas at the end of each hallway were provided for family to visit with residents. The DON reported that a residents' personal information should be covered for privacy so that it could not be seen. The DON reported that if a residents' information was left for public view the someone could steal it. The DON reported that is a residents' information was exposed then the residents' confidentiality would be affected.</p> <p>Record review of the facility provided policy titled, Resident Rights revised 11/28/16, revealed the following:</p> <p>Privacy and Confidentiality - The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161</p> <p>Based on observations, interviews, and record reviews the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission for 1 (Resident #228) of 19 residents reviewed for baseline care plans.</p> <p>The facility failed to ensure Resident #228's baseline care plan included information related to her diabetes and spinal fracture.</p> <p>This failure could place residents at risk of not receiving correct and/or necessary care/treatment.</p> <p>Findings included:</p> <p>Record review of Resident #228's face sheet dated 03/24/2025 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included fracture of first lumbar vertebra subsequent encounter for fracture with routine healing (spinal fracture) and Type 2 diabetes Mellitus without complications, unspecified fall, subsequent encounter, acute kidney failure, unspecified protein-calorie malnutrition, and Chronic respiratory failure with hypoxia (not enough oxygen in the blood).</p> <p>Record review of Resident #228's MDS face sheet revealed her admission MDS was not yet completed.</p> <p>Record review of Resident #228's baseline care plan completed on 03/18/2025 revealed no mention of her Type 2 diabetes or spinal fracture.</p> <p>Record review of Resident #228's Admission assessment completed on 03/18/2025 reflected no mention of her Type 2 diabetes or spinal fracture.</p> <p>Record review of Resident #228's active orders dated 03/18/2025 revealed the following:</p> <p>Humalog Kwik Pen Subcutaneous Solution Pen-Injector 100 unit/ml -Inject subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus without complications.</p> <p>PT/OT to evaluate and treat as indicated for primary diagnosis of fracture of first lumbar vertebra subsequent encounter for fracture with routine healing.</p> <p>During an observation and interview on 03/24/2025 at 09:57 AM, Resident #228 was dressed for the day and seated in her wheelchair in her room. Resident #228 stated she was a diabetic and received insulin for her diabetes. Resident stated she was in the facility for skilled care due to hurting her back during a fall.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 03/25/2025 at 11:00 AM, the DON stated when a resident was admitted to the facility an admission assessment was completed by the nurse on duty with the resident or resident's representative. The DON pulled the assessment up on his computer and demonstrated how the assessment auto populated the base line care plan. The DON stated that if something was missed or not available during the admission assessment the IDT would update that information when they met with the resident or resident's representative within 48 hours of admission.</p> <p>During an interview on 03/25/2025 at 1:45 PM, RN H stated the nurse on duty was responsible for ensuring care was put in the baseline care plan upon a resident's admission and a possible negative outcome for not having a correct care plan would be that staff would not be aware what a resident may need. RN H stated a base line care plan is to be completed within 48 hours.</p> <p>During an interview on 03/25/2025 at 1:52 PM, RN I stated the DON was responsible for ensuring care plans were completed timely and correctly because it revolved around patient safety.</p> <p>During an interview on 03/25/2025 at 3:07 PM, the Corp RN stated the nurses were responsible for ensuring care plans were put in the system timely and correctly but overall, it was the IDT's responsibility to ensure all care plans had resident's information in them. The Corp RN stated that if information was not in the care plan, then staff would not be aware how to care for a resident. The Corp RN stated that information during admission was not always available but said that it was the IDT's responsibility to get that information from the physician, the resident or their representative and put it in the base line care plan within 48 hours.</p> <p>Record review of a facility policy titled Baseline Care Plans (no date) revealed the following:</p> <p>This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standard of quality care. The baseline care plan will-</p> <p>Be developed within 48 hours of a resident's admission.</p> <p>Include the minimum healthcare information necessary to properly care for a resident including, but not limited to</p> <p>Initial goals based on admission orders.</p> <p>Physician orders.</p> <p>Therapy services.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #31) of 3 residents reviewed for respiratory care.</p> <p>The facility failed to store Resident #31's nasal cannula properly.</p> <p>This failure could affect residents by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition.</p> <p>Findings include:</p> <p>Record review of Resident #31's clinical record revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include pleural effusion (the buildup of excess fluid in the pleural space, the area between the lungs and the chest wall), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), pneumonia (lung inflammation caused by a bacterial or viral infection), and anxiety (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Record review of Resident #31's clinical record revealed her last MDS was a quarterly completed 3-7-2025 listing her with a BIMS score of 10 indicating she was moderately cognitively impaired, and she had a functionality of being dependent on staff for her activities of daily living such as dressing, bathing, and toileting. Section O-Special Treatments, Procedures, and Programs-Respiratory Programs: Oxygen Therapy-Resident #31 was marked as having oxygen While a Resident.</p> <p>Record review of Resident #31's Order Summary Report with Active Orders as of 3-18-2025 revealed the following order:</p> <p>- May use oxygen @_1-4___l/m via nasal canula every shift. Active 03-08-2025</p> <p>Record review of Resident #31's clinical record revealed a care plan with the admitted [DATE], which revealed the following:</p> <p>Focus: Resident has oxygen therapy as needed.</p> <p>Date Initiated: 12-14-2022.</p> <p>Date Revised: 3-25-2024.</p> <p>-there were no interventions for respiratory equipment care to include nasal cannula storage.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 03/24/25 at 08:53 AM Resident #31 was not present in her room. Her oxygen concentrator was next to her bed with her nasal cannula on the floor behind the concentrator. There were white specks of discoloration on the nasal prongs from use. A storage bag tied to the machine for proper storage not being used. Noted a date on the hydration bottle that was 3-7-2025.</p> <p>During an observation on 03/24/25 at 10:57 AM Resident #31's nasal cannula continued to be on the floor behind her oxygen concentrator. The date on the hydration bottle was still 3-7-2025. No date was on the nasal cannula or tubing. There continued to be white specks on the nasal prongs from previous use.</p> <p>During an observation on 03/24/25 at 12:13 PM Resident #31's nasal cannula continued to be on the floor behind her oxygen concentrator. The date on the hydration bottle was still 3-7-2025. No date was on the nasal cannula or tubing. There continued to be white specks on the nasal prongs from previous use.</p> <p>During an observation on 03/24/25 02:09 PM Resident #31's nasal cannula continued to be on the floor behind her oxygen concentrator. The date on the hydration bottle was still 3-7-2025. No date was on the nasal cannula or tubing. There continued to be white specks on the nasal prongs from previous use.</p> <p>During an observation and interview on 03/25/25 at 06:28 AM Resident #31 was up in her wheelchair dressed for the day wearing her oxygen via NC. There were slight white discolored flecks to the nasal prongs. A date of 3-7-2025 was on the hydration bottle and no date on the nasal cannula or oxygen tubing. Resident #31 stated, Ya, the staff put my oxygen on me last night. Resident #31 did not know which staff member place the oxygen on her the previous evening. Resident #31 reported no issues with her care.</p> <p>During an interview on 03/25/25 at 08:46 AM CNA G (assisting with Hall 100 this shift) who reported that staff are to complete rounds every 2 hours. Staff are to check if the resident was on oxygen and if the resident is wearing it properly, the hydration chamber is full, and the equipment is on. If the resident does not need the oxygen, then staff need to make sure the tubing and nasal cannula were stored correctly. CNA G reported that if the nasal cannula was on the floor, then it needed to be replaced because contact with the floor will contaminate the cannula and that staff do not want to put it on the residents nose. CNA G reported that if a nasal cannula that has been on the floor is put on a resident, then that resident would be at risk for infection.</p> <p>During an interview on 03/25/25 at 08:54 AM LVN C reported that staff were supposed to make rounds every two hours or more frequently if the residents need it. LVN C reported that staff were supposed to check a resident's oxygen and if the resident is on oxygen, do they have the nasal cannula on correctly and was it working. If the resident was not wearing the nasal cannula, then it should be stored correctly in a plastic bag off the floor. LVN C reported that if a nasal cannula was on the floor, then it should be immediately replaced. LVN C reported that if a nasal cannula was on the floor and then put on a resident it will place that resident at risk for infection.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/25 at 09:50 AM the DON reported that staff should make rounds as often as possible and should check a resident's oxygen when in the room. If the resident oxygen is not in use, then the tubing and cannula should be stored in a plastic bag. The DON reported that if a resident's oxygen cannula was on the floor, then it should be thrown away. The DON reported that if a nasal cannula that has been on the floor was placed on a resident's face, then it places that resident at risk for infection.</p> <p>During an interview on 03/26/25 at 10:14 AM the DON reported that the Oxygen Administration policy was the only policy the facility had on respiratory equipment. The DON reported that the facility did not have a specific policy on storage of the respiratory equipment like the nasal cannula and tubing. The DON reported that the facility stores the respiratory equipment in a bag off the floor for infection control.</p> <p>Record review of the facility provided policy titled, Oxygen Administration revised 02/13/07, revealed no information of the storage of respiratory equipment to include oxygen tubing and nasal cannula.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47854</p> <p>Based on observation and record review; it was determined the facility failed to provide pharmaceutical services that assure the accurate acquiring, receiving, and dispensing, and administration of all drugs and biologicals for 3 of 18 (Resident #39, Resident #65, and Resident #230) and 2 of 4 medication carts (Hall 300 and Hall 400) under review.</p> <p>-Resident #39's Lispro had an open date on it of 02/17/2025.</p> <p>-Resident #230's Lantus Solostar Pen had an open date on it of 02/08/2025.</p> <p>-1 bottle of Naproxen 220mg that had an expiration date of 02/2025.</p> <p>-Resident #65's Insulin Lispro with an open date of 02/19/2025.</p> <p>The facility's failure to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable could place all residents receiving medication at risk for drug diversion, drug overdose, and accidental or intentional administration to the wrong resident.</p> <p>Findings include:</p> <p>During an observation on 03/24/25 at 10:52 AM revealed Medication cart for 400 Hall having Resident #39's Lispro had an open date on it of 02/17/2025, and Resident #230's Lantus Solostar Pen had an open date on it of 02/08/2025.</p> <p>During an interview on 03/24/25 at 11:05 AM LVN B stated that the negative outcome for having medications with no open dates on them was the medications not being effective.</p> <p>During an observation on 03/24/25 at 11:38 AM revealed the medication cart for Hall 300 revealed Resident #65's Insulin Lispro with an open date of 02/19/2025. 1 bottle of Naproxen 220mg had an expiration date of 02/2025.</p> <p>During an interview on 03/24/25 at 11:46 AM LVN D stated that a negative outcome for having medications with no expiration dates was a medication being used that is not going to be effective.</p> <p>During an interview on 03/25/25 at 07:32 AM DON stated that a negative outcome for giving expired medications is that the medications could lose their effectiveness.</p> <p>Record review of facility provided policy titled, Recommended Medication Storage, Revised 07/2012, revealed the following:</p> <p>Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that is clear when the medication was opened.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility provided policy titled, Recommended Medication Storage, Revised 07/2012, revealed the following:</p> <p>Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that is clear when the medication was opened.</p>

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NAME OF PROVIDER OR SUPPLIER Five Points Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1625 Point West Parkway Amarillo, TX 79124	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47854</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable on 4 of 4 medication carts (Hall 100, Hall 200, Hall 300, and Hall 400) and 6 of 18 residents (Resident #27, #32, #47, #176, #228, and #229) reviewed for medication storage.</p> <ul style="list-style-type: none"> -Medication on bedside table of Resident #32. -Medication cart for Hall 200 revealed 25.5 unidentifiable loose pills in the medication cart drawers. -Medication cart for 400 Hall had 1.5 loose pills in the bottom of the medication cart drawers. -Resident #229's Stiolto Aer 2.5-2.5 had no open date. -Resident #228's Trelegy Ellipta had no open date. -Medication cart for 300 Hall had 1 bottle of Melatonin 3mg that did not have an expiration date on the bottle. -Medication Triamcinolone acetonide cream was on Resident #27's bed. -Medication cart for 100 Hall had 1 bottle of Aspirin 81mg with no expiration date on the bottle, and 1 Coreg pill was found in the bottom of the medication cart drawer -Resident #47 had a bottle of Aspirin 81mg on her bedside table. -Resident #176 had a tube of Neosporin ointment on her bedside table. <p>The facility's failures could place residents receiving medication at risk for drug diversion, lack of drug efficacy, and adverse reactions.</p> <p>Findings included:</p> <p>During an observation on 03/24/25 at 09:21 AM revealed a nasal spray bottle was on Resident #32's bedside table, the medication was identified as fluticasone propionate. The medication bottle had no open date on it. Resident #32 stated that the medication was not supposed to be in there with her.</p> <p>During an observation on 03/24/25 at 09:53 AM revealed 25.5 loose pills were loose in the medication cart drawers of the medication cart for Hall 200.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/24/25 at 10:13 AM LVN A stated that a negative outcome of having loose pills was a resident missing a dose of medication. LVN A also stated that a negative outcome of leaving medication on a resident's bedside table was to another resident possibly taking the medication or the resident forgetting that they took the medicine and taking another dose.</p> <p>During an observation on 03/24/25 at 10:52 AM revealed Medication cart for 400 Hall having 1.5 loose pills in the bottom of the medication cart drawers. Resident #229's Stiolto Aer 2.5-2.5 had no open date on the medication, Resident #228's Trelegy Ellipta had no open date on the medication. Resident #39's Lispro had an open date on it of 02/17/2025, and Resident #230's Lantus Solostar Pen had an open date on it of 02/08/2025.</p> <p>During an interview on 03/24/25 at 11:05 AM LVN B stated that the negative outcome for having medications with no open dates on them was the medications not being effective, and the negative outcome of having loose pills was that you don't know what it is.</p> <p>During an observation on 03/24/25 at 11:21 AM revealed the medication cart for Hall 100 had 1 bottle of Aspirin 81mg with no expiration date on the bottle and 1 Coreg pill was found in the bottom of the medication cart drawer. This pill was identified by LVN B.</p> <p>During an interview on 03/24/25 at 11:32 AM LVN B stated that a negative outcome for not having an expiration date on a bottle of medication could lead to giving expired medications. LVN stated that having loose pills in the bottom of the medication cart is that you might not know what it is or who it belongs to.</p> <p>During an observation on 03/24/25 at 11:38 AM revealed 1 bottle of Melatonin 3mg did not have an expiration date on the bottle.</p> <p>During an interview on 03/24/25 at 11:46 AM LVN D stated that a negative outcome for having medications with no expiration dates was a medication being used that is not going to be effective.</p> <p>During an observation on 03/24/25 at 02:27 PM revealed Resident #176 had a tube of Neosporin on her bedside.</p> <p>During an observation on 03/25/25 at 07:10 AM revealed a bottle of chewable Aspirin 81mg was on Resident #47's bedside table. When Resident #47 stated that she chews them and puts them on her teeth which cause her pain.</p> <p>During an interview on 03/25/25 at 07:32 AM DON stated that a negative outcome for having loose pills in the medication cart drawers would be first of all a sanitation issue. I hope the nurses don't use them; it could possibly lead to a missed dose. Nurses are responsible for making sure that the carts are clean and orderly.</p> <p>DON stated that a possible negative outcome for giving expired medications is that the medications could lose their effectiveness.</p> <p>DON stated that a possible negative outcome for having medications on a bedside table was another resident taking the medication and having a negative outcome.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility provided policy titled, Recommended Medication Storage, Revised 07/2012, revealed the following:</p> <p>Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that is clear when the medication was opened.</p> <p>.Fluticasone-expires 6 weeks (50mcg strength) or 2 months (100-250mcg) after initial use.</p> <p>.Insulins (vials, cartridge, pens) .</p> <p>.Humalog Flex Pen 75/25 and 50/50 pens</p> <p>Insulin Glargine (Lantus) .</p> <p>.expires 28 days after initial use regardless of product storage (refrigerated or roo temperature).</p> <p>Record review of facility provided policy titled, Medication Carts, dated 2003, revealed the following:</p> <p>1. Medication carts shall be maintained by the facility.</p> <p>.5. Carts should be clean.</p> <p>Record review of facility provided policy titled, Medication Administration Procedures, revised 10/25/2017, revealed the following:</p> <p>1. All medications are administered by licensed medical or nursing personnel.</p> <p>2. Medications are to poured, administered and charted by the same licensed person.</p> <p>Record review of facility provided policy titled, Recommended Medication Storage, Revised 07/2012, revealed the following:</p> <p>Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that is clear when the medication was opened.</p> <p>.Fluticasone-expires 6 weeks (50mcg strength) or 2 months (100-250mcg) after initial use.</p> <p>.Insulins (vials, cartridge, pens) .</p> <p>.Humalog Flex Pen 75/25 and 50/50 pens</p> <p>Insulin Glargine (Lantus) .</p> <p>.expires 28 days after initial use regardless of product storage (refrigerated or roo temperature).</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility provided policy titled, Medication Carts, dated 2003, revealed the following:</p> <ol style="list-style-type: none"> 1. Medication carts shall be maintained by the facility. .5. Carts should be clean. <p>Record review of facility provided policy titled, Medication Administration Procedures, revised 10/25/2017, revealed the following:</p> <ol style="list-style-type: none"> 1. All medications are administered by licensed medical or nursing personnel. 2. Medications are to poured, administered and charted by the same licensed person.

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 Nourishment Room reviewed for sanitation.</p> <ol style="list-style-type: none"> The facility failed to ensure freezer items were properly stored, labeled, and dated. The facility failed to ensure refrigerated foods were properly stored, labeled, and dated. <p>These failures could place residents who ate food served by the kitchen at risk of food-borne illness.</p> <p>Findings included:</p> <p>Observation of the refrigerator in the Nourishment Room on [DATE] at 08:55 AM revealed the following:</p> <ol style="list-style-type: none"> (2) containers of Orange Juice, both opened. No date or label. (1) 4-pack of yogurt smoothie drink, no date or label. (14) cups on tray with unidentified liquid inside, no labels, dates of [DATE] on lids. (1) chocolate milk container, opened, no date or label. <p>Observation of the freezer in the Nourishment Room on [DATE] at 9:01 AM revealed the following:</p> <ol style="list-style-type: none"> (1) box of opened Outshine bars, no date or label. (1) gallon of ice cream, opened and half gone, no date or label. (2) loose popsicles, no date or label. <p>In an interview on [DATE] at 9:01 AM, [NAME] J stated that that all dietary staff are responsible for the Nourishment Room to keep the refrigerator/freezer cleaned out and items labeled. [NAME] J stated that a possible negative outcome for not having labels and dates on items in the refrigerator/freezers could be that people could get sick if expired food was given to residents.</p> <p>In an interview on [DATE] at 9:18 AM, the DON stated that it was the dietary staff who were responsible for the nourishment room refrigerator/freezer.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on [DATE] at 11:18 AM, the DM stated that dietary staff are responsible for labeling and dating food in the nourishment room refrigerator and freezer. She stated a possible negative outcome for not labeling/dating food could be that a resident could get some old or outdated food and it could make them sick.</p> <p>Record Review of facility policy dated 2012 titled Storage Refrigerators, revealed in part:</p> <p>5. Food must be covered when stored, with a date label identifying what is in the container.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47854</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 8 staff (MA E and CNA K) reviewed for resident care</p> <p>-MA E did not perform hand hygiene before donning gloves to administer medicated eye drops to Resident #5.</p> <p>-CNA K did not perform hand hygiene or glove change after performing perineal care and placing a clean brief on Resident #45.</p> <p>These failures could place residents at risk of cross-contamination and infections.</p> <p>Findings include:</p> <p>During an observation on 03/25/25 at 08:03 AM MA E did not perform hand hygiene before donning gloves to administer medicated eye drops to Resident #5.</p> <p>During an interview on 03/25/25 at 08:09 AM MA E stated that a possible negative outcome for not performing hand hygiene before administering eye drops was contamination.</p> <p>During an interview on 03/25/25 at 08:51 AM DON stated that not performing hand hygiene before medications administration, was cross contamination, as the nurses hands could be dirty and they are touching the residents face.</p> <p>During an observation on 03/25/25 at 10:47 AM CNA K was performing perineal care on Resident #45 and did not change gloves or perform hand hygiene after cleaning the resident. CNA K then proceeded to place a clean brief on Resident #45 with the same gloves she had just performed perineal care with.</p> <p>During an interview on 03/25/25 at 11:03 AM CNA K stated that not changing gloves and performing hand hygiene between the dirty and clean areas of perineal care could lead to the spread of bacteria and lead to an infection.</p> <p>Record review of facility provided policy titled Fundamentals of Infection Control Precautions, revised 03/2024, revealed the following:</p> <p>1. Hand Hygiene</p> <p>Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene .</p> <p>.Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.Upon and after coming in contact with a resident's intact skin, .</p> <p>.after contact with a resident's mucous membranes and body fluids or excretions; .</p>