STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from 2/24/2025 to 2/28/2025. Survey findings included the investigation of a complaint. Complaint Number: CA00945854 The resident census at the time of survey was 150. Two deficiencies were identified for the complaint number: CA00945854 (Refer to F677 and F880).	F 000	This document will serve as a credible allegation of our intent to correct the deficient practice identified. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement, by the provider, of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907 **F552** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 34s physician provided informed consent for the use of Zoloft including the strength of medication and Resident 34's acceptance or refusal of recommended psychotherapeutic medications on 02/27/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents using psychotropic medications without complete physician informed consent including the dosage and the resident's choice to accept or refuse recommended medications are potentially affected by the facility practice. The Director of Medical Records/designee audited the	3/25/25
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:	F 552		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 3/24/25

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.

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F 552	Continued From page 1 Based on interview and record review, the licensed nursing staff failed to ensure the residents and/or responsible party (RP) were informed in advance, of the risks and benefits of psychoactive medication (a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior) for one (1) of 1 sampled resident (Resident 34) reviewed for informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to ensure the Zoloft (also known as sertraline, an antidepressant used to treat mental and mood disorders) informed consent indicated the milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) the resident was on, and the boxes were checked on the informed consent whether the resident consented to take the medication. This deficient practice violated the residents' right to make an informed decision regarding the use of psychoactive medications. Findings: During a review of Resident 34 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 9/15/2018, and readmitted the resident on 4/19/2022, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and acute respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (a condition where the body tissues are not getting enough oxygen).	F 552	physician orders for residents who receive psychotherapeutic medications to verify the presence of a completed informed consent in the medical record and to identify residents who may potentially affected by the facility practice on 3/20/2025. A total of 39 records were reviewed. 0 records were identified with incomplete informed consents. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development/designee will re-educate licensed nurses and social services employees on the facility's Informed Consent policy with emphasis on verifying informed consent for the use of psychotropic medications on or before, 03/20/2025. The DSD orients applicable new employees upon hire, annually, and as needed on the facility's Informed Consent policy and procedure including verifying informed consents are complete with the dosage of medication and the resident's choice for the use of recommended psychotherapeutic medications. The Director of Medical Records will audit the orders of residents' psychotropic medications to verify informed consent has been provided by the physician monthly including documentation of the dosage and resident's choice; and provide	

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F 552	Continued From page 2 During a review of Resident 34 ' s History and Physical (H&P), dated 2/8/2024, the H&P indicated the resident had depression, had logical thoughts, and had cooperative behavior. During a review of Resident 34 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/7/2024, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities, like thinking, remembering, reasoning, and understanding, are fully functioning and not significantly impaired, allowing them to perform everyday tasks normally). The MDS indicated the resident was on a high-risk drug class antidepressant medication. During a review of Resident 34 ' s Order Summary Report, dated 9/10/2024, the Order Summary Report indicated an order for Zoloft Oral Tablet 50 mg. Give 1 tablet by mouth 1 time a day for depression manifested by uncontrollable crying spells. Informed consent obtained by MD. During a review of Resident 34 ' s Psychotherapeutic Medication Informed Consent Form, dated 9/10/2024, the Psychotherapeutic Medication Informed Consent Form did not include the dose of Zoloft, and the boxes were not checked whether the resident consented to take the medication. During a concurrent interview and record review, on 2/26/2025, at 8:46 a.m., with Registered Nurse (RN) 1, Resident 34 ' s Order Summary Report and Informed Consent were reviewed. RN 1 confirmed and stated the dose was not listed on the Psychotherapeutic Medication Informed	F 552	completed audits to the Director of Nursing for tracking and trending analysis and further follow through as needed. The Director of Social Services will monitor resident physician order changes weekly to ensure residents using psychotropic medications have completed verified informed consent. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The IDT will review physician order changes four days weekly in the morning clinical meeting to ensure residents with orders for psychotherapeutic medications have evidence of a verified complete informed consent in the record. The Director of Staff Development will monitor the completion of staff training during new hire orientation, and as needed on the facility's Informed Consent procedures, including verification of complete informed consent for use of psychotropic medications. The Pharmacy Consultant shall monitor the medication regimen of residents each month to identify unnecessary medications and report the results to the Director of Nursing and QAA quarterly. The Director of Social Services will monitor the Medical Records verification of informed consent audit to identify variance to standard concerns and maintain compliance with this plan of correction.	

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F 552	Continued From page 3 Consent Form and the boxes were not checked whether the resident consented to take the medication. RN 1 stated it was important to have the dose and the boxes checked to ensure the resident was consenting to the use of the medication. During a concurrent interview and record review, on 2/28/2025, at 9:19 a.m., with the Director of Nursing (DON), Resident 34 ' s Psychotherapeutic Medication Informed Consent Form was reviewed. The DON confirmed and stated the dose of the medication Zoloft was not indicated and the boxes whether the resident or representative consented to the use of the medication was not marked with a check on Resident 34 ' s Psychotherapeutic Medication Informed Consent Form. The DON stated the dose should be indicated on the form because when the medication dose gets increased, they have to get a new consent, and the boxes should be checked to ensure they honor the resident ' s right to informed consent. During a review of the facility's recent policy and procedure (P&P) titled, "Informed Consent," last reviewed on 12/3/2024, the P&P indicated the facility provides with all information that is material to an individual resident ' s decision concerning whether to accept or refuse any proposed treatment or procedure including the disclosure of material information for administration of psychotherapeutic drugs or physical restraints of the prolonged use of a device that may lead to the inability to regain use of a normal bodily function.	F 552	The Director of Nursing/designee will report significant trends identified to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 03/25/2025. **F584** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Maintenance Director/designee removed Resident 83 and 42 floor mats on 2/27/2025. Resident 42 and Resident 83 were provided new floor mats on 2/27/2025. The IDT reviewed and revised Resident 83 and Resident 42 with their current interventions. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** The Nurse Supervisor/designee completed a room audit of all residents on 3/18/2025 to identify residents who may have floor mats in disrepair.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584	No additional residents were identified with floor mats in disrepair.	

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F 584	Continued From page 4 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	No other residents were affected by the facility's current practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development/designee will re-educate nursing staff on the facility policy Homelike Environment with emphasis on floor mats should be in good condition without rips or tears. Re-education will be completed on or before 3/21/2025. The Central Supply Clerk will utilize the device consent audit and special needs/precautions list to ensure all devices and safety precautions are compliant. The Interdisciplinary Team will evaluate residents for the use of floor mats during their comprehensive audits and as needed. Floor mats for resident use will be inspected by the Director of Maintenance prior to being placed in a resident's room. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The DSD/Central Supply staff will monitor the floor mats in residents' rooms weekly to ensure floor mats are in good repair without tears or rips. Floor mats identified in disrepair including tears in the covering will be removed immediately at the time of observation and replaced with a floor mat in good repair.	

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F 584	Continued From page 5 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for two (2) of 2 sampled residents (Residents 83 and 42) reviewed during a random observation by failing to ensure Resident 83 ' s and 42 ' s floor mats were free from rips and disrepair. This deficient practice had the potential to negatively affect the resident ' s quality of life. Findings: a. During a review of Resident 83 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/23/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), speech disturbances, and generalized muscle weakness. During a review of Resident 83 ' s History and Physical (H&P), dated 12/29/2024, the H&P indicated Resident 83 had the capacity to make decisions. During a review of Resident 83 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 83 had intact cognition (mental action or process of acquiring knowledge and understanding) and required total assistance with sit to stand activities and transfers; partial/moderate assistance with eating, oral hygiene, and personal	F 584	The Director of Staff Development will monitor the completion of staff training during new hire orientation, annually and as needed on the facility's homelike environment practices including equipment must be in good repair. The Director of Nursing/designee will report significant trends identified to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025	

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F 584	Continued From page 6	F 584		

hygiene; substantial/maximal assistance from staff with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily).

During a review of Resident 83 ' s fall risk assessments dated, 12/23/2024, 1/21/2025, and 2/33/2025, the fall risk assessments indicated the resident was a high risk for falls.

During a review of Resident 83 ' s Order Summary Report, dated 1/29/2025, the Order Summary Report indicated a physician ' s order for landing mats to minimize injury every shift for safety.

During a review of Resident 83 ' s care plan (CP) on risk for recurrent falls and spontaneous injury, initiated on 5/18/2021 and last revised on 2/24/2025, the CP indicated landing mat as one of the interventions to prevent falls.

During a concurrent observation and interview, on 2/24/2025, at 9:49 a.m., inside Resident 83 ' s room, Resident 83 ' s landing mat laid on the right side of Resident 83 ' s bed with the lower portion of the mat torn off in the middle.

During a concurrent observation and interview, on 2/24/2025, at 9:56 a.m., inside Resident 83 ' s room, with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 83 ' s right landing mat had a portion of the lower part of the mat torn off. LVN 4 stated if staff observed any equipment or furniture in the room in disrepair, the maintenance department should be notified to replace the equipment, such as landing mats. LVN 4 stated staff should have notified the maintenance department and that the landing

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F 584	Continued From page 7 mat should have been replaced as it is not homelike when any equipment in the room is damaged or torn off. During an interview, on 2/28/2025, at 12:30 p.m., with the Director of Nursing (DON), the stated Resident 83 ' s landing mat had a portion of the lower part torn off in the middle. The DON stated the staff should notify the maintenance department to replace the damaged landing mat. The DON stated the staff should have notified the maintenance department and the landing mat should have been replaced as the facility was not providing the residents a homelike environment. The DON stated not providing a clean and homelike environment can potentially affect Resident 83 ' s quality of life as the facility is their temporary home while they recover. During a review of the facility ' s policy and procedure (P&P) titled, "Homelike Environment," last reviewed on 12/3/2024, the P&P indicated: The facility strives to provide a personalized, homelike environment which recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. The facility environment should enhance the quality of life for residents in accordance with resident preferences. It is the responsibility of all facility staff to create a "homelike" environment and promptly address any cleaning needs. b. During a review of Resident 42 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/30/2024 with	F 584		

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F 584	Continued From page 8 diagnoses including malignant neoplasm of left female breast (abnormal growth of tissue that can spread to other parts of the body), difficulty in walking, and generalized muscle weakness. During a review of Resident 42 ' s H&P, dated 12/31/2024, the H&P indicated Resident 42 had the capacity to make decisions. During a review of Resident 42 ' s MDS, dated 1/5/2025, the MDS indicated Resident 42 had intact cognition and required partial/moderate assistance from staff with all ADLs. During a review of Resident 42 ' s fall risk assessment, dated 12/30/2024, the fall risk assessment indicated the resident was a high risk for falls. During a review of Resident 42 ' s Order Summary Report, dated 12/30/2024, the Order Summary Report indicated a physician ' s order for landing mats to minimize injury. During a review of Resident 42 ' s CP on risk for recurrent falls and spontaneous injury, initiated on 12/31/2024 and last revised on 1/9/2025, the CP indicated landing mats as one of the interventions to prevent falls.	F 584		

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F 584	Continued From page 9 During an observation, on 2/24/2025, at 10:40 a.m., inside Resident 42 ' s room, Resident 42 ' s landing mat laid on the right side of the resident ' s bed with a portion of the right side ripped off. During a concurrent observation and interview, on 2/24/2025, at 11:00 a.m., inside Resident 42 ' s room, with Treatment Nurse (TN) 2, TN 2 confirmed Resident 42 ' s landing mat laid on the right side of the resident ' s bed with a portion of the right side ripped off. TN 2 stated if staff observed any equipment or furniture in the room is in disrepair, the maintenance department should be notified to replace the equipment. TN 2 stated staff should have notified the maintenance department and that the landing mat should have been replaced as it is not homelike when any equipment in the room is damaged or torn off. During an interview, on 2/28/2025, at 12:30 p.m., with the DON, the DON stated Resident 42 ' s landing mat had a portion of the right side ripped off. The DON the staff should notify the maintenance department to replace any damaged landing mat. The DON stated the staff should have notified the maintenance department and the landing mat should have been replaced as the facility was not providing the residents a homelike environment. The DON stated not providing a clean and homelike environment can potentially affect Resident 42 ' s quality of life as the facility is their temporary home while they	F 584		

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F 584	Continued From page 10 recover. During a review of the facility ' s P&P titled, "Homelike Environment," last reviewed on 12/3/2024, the P&P indicated: The facility strives to provide a personalized, homelike environment which recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with the past and family members. The facility environment should enhance the quality of life for residents in accordance with resident preferences. It is the responsibility of all facility staff to create a "homelike" environment and promptly address any cleaning needs.	F 584	F604 **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The pad alarm in Resident 303's room was removed on 2/27/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents using pad alarms in the absence of device/restraint assessment, physician order and care plan are potentially affected by the facility practice. The DSD/designee completed a room audit of all residents on 2/27/2025 to identify residents who may pad alarms to verify the presence of a physical device/restraint assessment, physician order, informed consent and care plan. A total of 149 records were reviewed. 2 records were identified without a physician order, informed consent care plan or device/restraint assessment present in the medical record. The list of residents with pad alarms identified without a device/restraint assessment, physician order, informed consent or care plan were provided to the DON for correction on 02/27/2025.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 604		

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F 604	Continued From page 11 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident ' s body that he or she cannot easily remove that restricts freedom of movement or normal access to one ' s body) for one (1) of two (2) sampled residents (Resident 303) reviewed for physical restraints by failing to ensure the resident had a physician ' s order, an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), a device use or restraint assessment, and a care plan for bed pad (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) alarm while in bed.	F 604	**C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development will re-educate licensed nurses and the IDT on the facility's Physical Restraints policy with emphasis on verifying informed consent, obtaining a physician order, developing a care plan and completing a device/restraint assessment for the use of devices having the potential to become an unnecessary restraint on or before, 3/20/2025. The DSD orients new employees upon hire, annually, and as needed on the facility's Restraint policy and procedure including verifying informed consent, care planning, physician order and assessments for use of devices. The Director of Medical Records will audit the orders of residents' devices to ensure there is documented verification informed consent, care planning, device/restraint assessment and physician order are present in the record. Results of the audit will be provided by the physician; and provide completed audits to the Director of Nursing for tracking and trending analysis and further follow through as needed. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Staff Development will	

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 604	Continued From page 12 This deficient practice placed Resident 303 at risk for restriction of resident ' s freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: During a review of Resident 303 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 12/20/2024 and readmitted Resident 303 in the facility on 2/5/2025, with diagnoses including ESRD (End Stage Renal Disease-irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and generalized muscle weakness. During a review of Resident 303 ' s History and Physical (H&P), dated 2/7/2025, the H&P indicated Resident 303 had the capacity to make medical decisions. During a review of Resident 303 ' s Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2025, the MDS indicated Resident 303 had the ability to make self-understood and understand others and had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 303 had no upper and lower extremity impairment. The MDS indicated Resident 303 required substantial/maximal assistant to total assistance from staff with all activities of daily	F 604	monitor the completion of staff training during new hire orientation, and as needed on the facility's devices and restraints procedures, including verification of informed consent, care planning, physician order and assessment for use of bed/pad alarms. The Director of Nurses will monitor the Medical Records device and restraint audit to ensure all required components have been completed to identify variance to standard concerns and maintain compliance with this plan of correction. The Director of Nursing/designee will report significant trends identified to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date: 3/25/2025**	

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F 604	Continued From page 13	F 604		

living (ADLs- activities such as bathing, dressing and toileting a person performs daily).

During a review of Resident 303 ' s Order Summary Report, the Order Summary Report did not indicate an order for bed pad alarm.

During a review of Resident 303 care plan (CP) on risk for falls and spontaneous injuries, initiated on 2/6/2025 and last revised on 2/24/2025, the CP did not indicate bed pad alarm as one of the interventions to prevent risk of injury from falls.

During a review of Resident 303 ' s fall risk evaluation, dated 2/5/2025, the fall risk evaluation indicated Resident 83 was a high risk for falls.

During multiple observations, on 2/24/2025, at 11:36 a.m., and 2/25/2025, at 1:31 p.m., inside Resident 303 ' s room, Resident 303 laid in bed asleep with a bed alarm box hanging on the right side of the bed.

During a concurrent observation and interview, on 2/26/2025, at 9:30 a.m., inside Resident 303 ' s room, with the Director of Staff Development (DSD), the DSD confirmed and stated Resident 303 had a bed alarm box hanging on the right side of the bed. The DSD confirmed and stated the green light on the bed alarm box blinked to indicate it functioned. The DSD stated she was not sure if Resident 303 had a physician ' s order for the use of bed pad alarm while in bed.

During a concurrent interview and record review, on 2/26/2024, at 2:30 p.m., with the Assistant Director of Nursing (ADON), Resident 303 ' s medical record, including physician ' s orders, informed consent, device/physical restraint

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F 604	Continued From page 14	F 604		

assessment, and care plan were reviewed. The ADON confirmed and stated there was no physician ' s order, informed consent, device/physical restraint use assessment completed, and care plan developed for the use of bed pad alarm for Resident 303. The ADON stated prior to use of any type of restraint, the licensed nurses must complete a device use/physical restraint assessment, obtain an order from the physician, obtain written informed consent from the resident or resident representative, and develop a care plan. The ADON stated a device use/physical restraint assessment should have been completed, a physician ' s order and informed consent from the resident or resident representative should be obtained, and a care plan should be developed prior to use of the bed pad alarm on Resident 303. The ADON stated the purpose of device use/physical restraint assessment was to ensure the use of bed alarm for Resident 303 was appropriate. The ADON stated the purpose of the physicians ' order is for the physician to be aware of Resident 303 ' s current condition and plan of care. The ADON stated the purpose of the informed consent is to give the resident and/or representative the option to accept or decline the proposed treatment. The ADON stated the purpose of the care plan is for the staff to be aware of the proper intervention for Resident 303 ' s safety.

During an interview, on 2/28/2025, at 1:30 p.m., with the Director of Nursing (DON), the DON stated the staff should have obtained a physician ' s order, obtained an informed consent from the resident/representative, assessed the resident for appropriateness on the use of the restraint, and developed and implemented a care plan on the

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F 604	Continued From page 15	F 604		

prior to use of bed pad alarm for Resident 303. The DON stated it was important to have all those elements to ensure safe use of the bed pad alarm to honor Resident 303 or representative right to accept or decline the proposed treatment. The DON stated if these elements were not present, the facility applied the restraint against Resident 303 ' s will and restricts her freedom to move freely.

During a review of the facility ' s policy and procedure (P&P) titled, ""Informed Consent," last reviewed 12/3/2024, the P&P indicated: The facility provides with all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure including the disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function It is the responsibility of the prescribing physician, or approved licensed healthcare provider, to personally examine and obtain a written informed consent, whereby applicable an indicated by state & federal regulations, from a resident or their representative for the use of: Physical restraints.

During a review of the facility ' s P&P titled, "Respect and Dignity - Physical Restraints," last reviewed 12/3/2024, the P&P indicated: The facility does not use physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. "Physical Restraints": Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot

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F 604	Continued From page 16 remove easily which restricts freedom of movement or normal access to one's body (e.g. leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, and lap trays the resident cannot remove easily). 1. The facility limits the use of any physical restraint to circumstances in which the resident has medical symptoms that warrant the use of restraints. 2. Staff shall document the medical symptoms being treated and the reason[s)a restraint is warranted. 3. The licensed nurse shall obtain a physician's order for the use and specific type of restraint. 4. The interdisciplinary team shall complete a physical restraint assessment to identify potential risks associated with the restraint use, specific to the resident. 5. The interdisciplinary team will complete a resident centered care plan, based on the restraint assessment with individualized interventions for care.	F 604	**F640 Accuracy of Assessments CFR(s): 483.20(g)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 126's discharge assessment was transmitted 2/25/2025 and accepted into the QIES system on 2/25/2025. The Nurse Consultant/designee re-educated the MDS Nurse re: Transmitting Resident Assessments Timely on 3/24/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** The MDS Nurse completed an audit of resident discharge assessments 1/1/2025 through 3/01/2025 to ensure resident discharge assessments were completed and submitted ad required by the RAI. All other resident discharge assessment locations were coded accurately. No other residents were identified as affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The MDS Consultant/designee will re-educate the MDS Nurse and MDS	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there	F 640		

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F 640	Continued From page 17 is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to transmit the Minimum Data Set (MDS-a resident assessment tool) Assessments for one	F 640	support staff on the facility policy and procedure Resident Assessment Instrument, with emphasis on timely submission and discharge assessments on 3/24/25. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The MDS Consultant/designee will monitor timely completion and submission of Resident discharge assessments. Concerns identified will be reported to the Director of Nursing and MDS Nurse for immediate completion of modification assessment and submission to QIES. The Director of Nursing/designee will report trends identified in the MDS Consultant audits to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction; and potential termination of this plan of correction when substantial compliance has been met. Substantial compliance shall be indicated at the discretion of the QAA Committee following three consecutive evaluations of MDS audit reports without findings of a variance to standard. **Allegation of Compliance Date 3/25/2025.**	

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F 640	Continued From page 18 of two sampled residents (Resident 126) reviewed under Resident Assessments facility task by, failing to transmit Resident 126's MDS discharge assessment. This deficient practice had the potential to negatively affect the provision of necessary care and services needed by the resident. Findings: During a review of Resident 126's Admission Record, the Admission Record indicated the facility admitted the resident on 9/30/2024 with diagnoses including fracture ((bone that is broken in at least two places) of the neck of the left femur (thigh bone), gout (a painful form of arthritis [inflammation (or stress) of joints] caused by uric acid crystals that form in and around the joints), and alcohol abuse. During a review of Resident 126's MDS dated 10/1/2024, the MDS indicated the resident had the capacity to understand and make decisions. During a review of Resident 126's physician order, the physician order indicated to discharge the resident home on 10/23/2024 with home health care (a medical care provided in the resident's home) to include physical therapy, occupational therapy, and home health aide (a home healthcare worker who helps patients with basic medical tasks and assists with everyday tasks). During an interview on 2/28/2025 at 8:54 a.m., the Director of Nursing (DON) stated when a resident is discharged, the MDS Assessments should be completed and submitted based on the	F 640		

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F 640	Continued From page 19 MDS calendar. The DON stated when the MDS Assessments are not transmitted timely it can potentially affect the appropriate billing, resident assessment, and data on their facility's quality measures and CMS indications that they are taking care of Resident 126 in the facility. During a concurrent interview and review on 2/27/2025 at 3:03 p.m. with MDS Nurse (MDSN) 2, the Final Validation Report (facility's documentation of successful MDS file submission), dated 2/25/2025 was reviewed. The Final Validation Report indicated Resident 126's MDS assessment was completed late. MDSN 2 stated they identified that Resident 126's MDS Discharge Assessment was late, and the assessment was submitted this week on 2/25/2025. During an interview on 2/28/2025 at 10:53 a.m., with MDSN 1, MDSN 1 stated Resident 126's MDS Discharge should have been transmitted on 11/20/2024 and if transmitted after this date it was considered late. MDSN 1 stated they missed Resident 126's MDS Discharge Assessment and they submitted it on 2/25/2025 which was considered late. During a review of the Centers for Medicare & Medicaid Services (CMS, a federal agency that administers a major healthcare programs) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, the RAI manual indicated providers must transmit all sections of the MDS 3.0 required for their State-specific instrument and all tracking or correction information. The MDS must be transmitted electronically no later than 14 calendar days after the MDS completion date.	F 640		

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F 640	Continued From page 20 During a review of the facility's policy and procedure (P&P) titled, "RAI OBRA Required Assessment Summary," last reviewed 12/3/2024, the P&P indicated "the Discharge Assessment - return not anticipated (Non-Comprehensive)'s MDS Completion Date no later than Discharge Date +14 calendar days and Transmission Date No Later Than MDS Completion Date +14 calendar days".	F 640	**F641** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The MDS added on 2/27/25 the diagnosis of Dementia to the list of active diagnosis RT conducted an assessment on resident 29 for his CPAP on 2/26/2025 Resident 104's name was corrected in her MDS on 2/18/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** The Director of Nursing and Nurse Managers audited the MDS completion of Residents with diagnoses dementia to ensure resident assessments were accurate and included a diagnosis of dementia under section I to identify other resident's with diagnoses of dementia not accurately documented under section I on 3/17/2025. The DON and Nurse Managers audited a total of 30 resident MDS assessments. The MDS Nurse submitted a correction on 5 of 30 resident assessments requiring corrections to section I.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents receive an accurate assessment, reflective of the residents' status at the time of the assessment by: 1. Failing to accurately complete the Minimum Data Set (MDS - a resident assessment tool) on a diagnosis of dementia (a group of progressive medical conditions affecting the brain that interfere with the ability to remember, think clearly, and make decisions) for one of five residents sampled for unnecessary medications (Resident 71.) This deficient practice increased the risk that Resident 71 may not have received care planning and treatment according to her needs possibly leading to a decline in her overall health and well-being.	F 641		

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F 641	Continued From page 21 2. Failing to ensure an accurate assessment is conducted for one of three sampled residents (Resident 29) reviewed for accuracy of assessment by failing to indicate in the MDS that Resident 29 had a home continuous positive airway pressure (CPAP, is a machine that uses mild air pressure to keep breathing airways open while you sleep) machine in use at the facility. This deficient practice has the potential to result in Resident 29's delay in necessary care and treatment. 3. Failing to accurately code Resident 104's MDS to reflect the resident's legal name as it appears on the resident's government-issued identification card/Medicare (a federal health insurance program for people age 65 or older)/Medicaid (a joint federal and state program that helps cover medical costs for some people with limited income and resources) insurance card. This deficient practice had the potential to affect Resident 104's plan of care and delivery of necessary care and services. Findings: 1. During a review of Resident 71's Admission Record (a document containing a resident's diagnostic and demographic information), dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 7/16/2021 and most recently readmitted on 1/31/2024 with diagnoses including: schizophrenia (a mental illness characterized by hearing or seeing things that are not there.) During a review of Resident 71's History and	F 641	**C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The MDS Consultant/designee will re-educate the MDS Nurse and MDS support staff on the facility policy and procedure Resident Assessment Instrument, with emphasis on accurate completion of the MDS including section I active diagnoses. The MDS nurse will work with the business office to obtain the residents government issued ID/common working file in order to accurately reflect the residents legal name. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Medical Records Director/designee will monitor MDS accuracy of section I and the residents active diagnosis list for five records monthly for three months. The Medical Records Director/Designee will get the common working file/government ID of all patients to audit the accuracy of name once a month. Concerns identified will be reported to the Director of Nursing and MDS Nurse for immediate completion of modification assessment and submission to QIES. The Director of Nursing/designee will report trends identified in the Medical Records audits to the QAPI/QAA Committee at least quarterly for the purpose of process improvement	

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F 641	Continued From page 22 Physical (H&P - a record of a comprehensive physician's assessment), dated 11/23/2024, the H&P indicated she had the capacity to understand and make decisions. During a review of Resident 71's Physician Order Summary (a monthly summary of all active physician orders), dated 2/26/2025, the Physician Order Summary indicated she was prescribed donepezil (a medication used to treat dementia) five (5) milligrams (mg - a unit of measure for mass) by mouth at bedtime for "dementia" on 1/31/2024. During a review of Resident 71's Care Plan (a resident-specific plan of care used to guide treatment and caregivers concerning a resident's medical issues), dated 2/1/2024, the Care Plan indicated Resident 71 had "impaired function/dementia" for which the use of donepezil was indicated as a targeted intervention. During a review of Resident 71's MDS Section I, dated 11/28/2024, the MDS Section 1 indicated Resident 71 did not have dementia as an active diagnosis. During an interview on 2/26/2025 at 2:58 p.m., with MDS nurse (MDSN) 2, MDSN 2 stated Resident 71's pre-admission paperwork, dated 1/31/2024, did not include dementia in a diagnosis list despite donepezil listed as an active medication. MDSN 2 stated donepezil is only used to treat dementia, and thus the physician should have been called to clarify the order at that time to determine if Resident 71 had dementia. MDSN 2 stated, since this was not done, the MDS assessment completed upon Resident 71's admission did not include a diagnosis of dementia	F 641	through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction; and potential termination of this plan of correction when substantial compliance has been met. Substantial compliance shall be indicated at the discretion of the QAA Committee following three consecutive evaluations of MDS audit reports without findings of a variance to standard. Allegation of Compliance Date **3/25/2025.**	

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 641	Continued From page 23 despite the use of donepezil to treat dementia. MDSN 2 stated this error was likely carried through in subsequent assessments up to the present and explains why a diagnosis of dementia is not on Resident 71's diagnosis list or the assessment done on 11/28/24. MDSN 2 stated this increased the risk that the facility staff did not develop a resident-centered care plan for dementia which could have led to a decline in Resident 71's functional or psychosocial status. During a review of the facility's recent policy and procedures (P&P) titled "Accuracy of Assessments," last reviewed on 12/3/2024, the P&P indicated, "The facility ensures each resident received an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline ... The assessment must represent an accurate picture of the resident's status during the observation period of the MDS ..." 2. During a review of Resident 29's Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2025, with diagnoses including chronic obstructive pulmonary disease (COPD, a lung disease that makes it hard to breathe), asthma (is a chronic (long-term) condition that affects the airways in the lungs), and obstructive sleep apnea (the most common sleep-related breathing disorder). During a review of Resident 29's H&P, dated 1/23/2025, the H&P indicated the resident had obstructive sleep apnea and was on CPAP at bed time. The H&P indicated the resident had the capacity to understand and make decisions.	F 641		

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F 641	Continued From page 24 During a review of Resident 29's MDS, dated 1/29/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (someone's mental abilities, like thinking, remembering, understanding, and reasoning, are fully functional and working normally, with no significant impairments or decline in cognitive skills). The MDS did not indicate the resident was on a home CPAP machine at the facility. During a review of Resident 29's Order Summary Report, dated 2/28/2025, the Order Summary Report did not indicate an order for home CPAP use in the facility. During an observation and interview on 2/24/2025, at 9:56 a.m., inside Resident 29's room, observed Resident 29 with a CPAP on. Resident 29 stated he came in the facility with the home CPAP machine, and nobody had checked the machine and the CPAP mask, and the tubing were not changed for a few weeks now. During an observation on 2/26/2025 at 8:29 a.m., with Registered Nurse (RN) 1, inside Resident 29's room, observed Resident 29 wearing his home CPAP. During an interview and record review on 2/26/2025, at 2:56 p.m., with MDSN 2, reviewed Resident 29's MDS Assessment, dated 1/29/2025. MDSN 2 stated she did the Resident 29's MDS and she did not see the home CPAP when she did her assessment. MDSN 2 stated the staff should have reported to her the presence of home CPAP at the facility for MDSN 2 to update the MDS Assessment. MDSN 2 stated it was important to ensure the CPAP	F 641		

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F 641	Continued From page 25	F 641		

machine use was captured on the MDS Assessment to give an accurate picture of the resident to implement a comprehensive care plan. MDSN 2 stated the failure of the staff to report to her the presence of a home CPAP had led to the home CPAP not having an order, the resident was not assessed on its use, and no care plan was developed and implemented.

During an interview on 2/28/2025, at 9:22 a.m., with the Director of Nursing (DON), the DON stated the Resident 29's MDS dated 1/29/2025 should have been coded that the resident was using a home CPAP while at the facility to reflect the accurate picture of the resident for care planning. The DON stated even though the MDSN 2 did not see the home CPAP, the staff should have reported it to MDSN 2 to update the MDS Assessment. The DON stated providing an accurate assessment of the resident can help provide appropriate and relevant care to the resident.

During a review of the facility's recent P&P titled "Resident Assessment," last reviewed on 12/3/2024, the P&P indicated the facility uses the Resident Assessment Instrument (RAI, is a tool used in nursing homes to assess residents' needs and strengths) in accordance with special format and timeframes as set forth by Centers for Medicare & Medicaid Services (CMS, a federal agency that administers major healthcare programs). The facility conducts initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Using the RAI provided by CMS, the facility develops a comprehensive assessment of a resident's needs, strengths, goals, life history and

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F 641	Continued From page 26 preference. The assessment minimally includes the following: -Special treatments and procedures. During a review of the facility's recent P&P titled "Accuracy of Assessments," last reviewed on 12/3/2024, the P&P indicated the facility ensures each resident receives accurate assessment, reflective of the resident's status at the times of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline. 3. During a review of Resident 104's Admission Record, the Admission Record indicated the resident was admitted on 1/22/2024 with diagnoses including anoxic brain injury (caused by a complete lack of oxygen to the brain), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia, and essential (primary) hypertension (high blood pressure). During a review of Resident 104's physician progress note, dated 2/2/2025, the physician progress note indicated the resident does not have the capacity to make decisions. During a concurrent interview and record review on 2/27/2025 at 3:05 p.m. with MDSN 2, reviewed Resident 104's MDS Assessments Section A0500 Question History. MDSN 2 stated Resident 104's last name on the MDS Assessments Section A0500 Question History did not match the resident's Medicaid insurance card for the following assessments: - 1/22/2024, Entry - 1/29/2024, Comprehensive Assessment - 7/24/2024, Quarterly Assessment	F 641		

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F 641	Continued From page 27 - 10/17/2024, Quarterly Assessment - 4/30/2024, Quarterly Assessment During an interview on 2/28/2025 at 9:01 a.m. with the DON, the DON stated resident's legal name should be entered correctly because they are ensuring right services to the right person and the identified person in that billing is accurate. During a concurrent interview and record review on 2/28/2025 10:16 a.m., reviewed the CMS Long-Term Care Facility RAI 3.0 User's Manual, dated 10/2024, with MDSN 1. MDSN 1 stated the RAI manual indicated the "Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document." MDSN 1 stated they will submit an MDS modification assessment to reflect the resident's legal name according to the RAI manual. During a review of the facility's recent P&P titled "Accuracy of Assessments," last reviewed on 12/3/2024, the P&P indicated the facility ensures each resident receives accurate assessment, reflective of the resident's status at the times of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.	F 641	**F655** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 68's diagnosis of dementia was added to her comprehensive assessment and care plan on 1/29/25. Resident 68's antipsychotic was discontinued on 2/14/25. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** All residents have the potential to be affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The MDS Consultant/designee will re-educate the MDS Nurse and MDS support staff on the facility policy and procedure Baseline Care Plan with emphasis on diagnosis and medication care planning on 3/24/25.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655	The IDT will review the baseline care plan of newly admitted the following business day to ensure the plan includes the necessary information to care for the resident including diagnoses which may affect the resident's psychosocial well-being and psychotherapeutic medications which may affect the resident's quality of life.	

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F 655	Continued From page 28 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. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655	The comprehensive care plan may be developed instead of the baseline care plan for diagnoses such as dementia and the use of psychotherapeutic medications within 48 hours of the resident's admission. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Staff Development provides education regarding the baseline care plan, including pertinent diagnoses which may affect the residents psycho-social well-being and use of psychotherapeutic medications during new employee orientation, annually and as indicated when a variance to performance is identified. The MDS Nurse completes verifies the resident's comprehensive plan of care no later than 21 days following admission and evaluates the completion of the baseline care plan to identify any process concerns. The MDS Nurse will report significant trends to the DON for further review, analysis and correction. The DON/designee will report significant trends identified in the MDSN and IDT audits to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction; or for the	

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F 655	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Include a diagnosis of dementia (a group of progressive medical conditions affecting the brain that interfere with the ability to remember, think clearly, and make decisions) on the baseline care plan (an initial set of instructions needed to provide resident-centered care to a newly admitted resident) for one of five residents sampled for unnecessary medications (Resident 68). 2. Include the use of the antipsychotic (a class of medications used to treat mental illness) medication, quetiapine (a medication used to treat mental illness), on the baseline care plan for one of five residents sampled for unnecessary mediations (Resident 68). These deficient practices of failing to include a diagnosis of dementia and the use of quetiapine on Resident 68's baseline care plan increased the risk that Resident 68 may not have received resident-centered care and planning unique to her needs possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 68's Admission Record (a document containing a resident's diagnostic and demographic information), dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 1/22/2025 with diagnoses including: dementia.	F 655	purpose of terminating this plan of correction when substantial compliance has been achieved. **Allegation of Compliance Date: 3/25/2025.**	

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F 655	Continued From page 30 During a review of Resident 68's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 1/24/2025, the H&P indicated she did not have the capacity to understand and make decisions. During a review of Resident 68's Order Audit Report (a report containing details and a timeline regarding a specific physician order), dated 2/26/2025, the Order Audit Report indicated she was prescribed quetiapine 75 milligrams (mg - a unit of measure for mass) by mouth at bedtime for "adjunct treatment of depression manifested by physical aggression" between 1/22/2025 and 1/29/2025. During a review of Resident 68's baseline care plans, dated 1/22/2025, the baseline care plans indicated no care plans addressed Resident 68's diagnosis of dementia or use of quetiapine upon her admission to the facility. During an interview on 2/27/25 at 9:20 a.m., with the Director of Nursing (DON), the DON stated when a resident is first admitted the facility, facility staff create a baseline care plan for them to address care areas of greatest concern. The DON stated as the resident is here longer, care plans are revised and improved to become more resident-specific. The DON stated it is very important that a diagnosis of dementia is included on the baseline care plan so that the facility can address specific behaviors and challenges to providing a resident's care that may arise from dementia. The DON stated, when Resident 68 was admitted on 1/22/2025, the facility failed to include her diagnosis of dementia in her baseline care plan. The DON stated this increased the risk	F 655		

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F 655	Continued From page 31 that her specific needs and challenges related to her dementia diagnosis may not have cared for in an optimized way which could have led to a decline in her physical, mental, or psychosocial well-being. The DON stated the facility also failed to include that Resident 68 was receiving the antipsychotic, quetiapine, in her baseline care plan. The DON stated using antipsychotics, especially in residents with dementia, increases the risk that they may experience adverse effects related to their use. The DON stated failure to include antipsychotic therapy on the baseline care plan increased the risk that Resident 68 could have had adverse effects related to antipsychotic therapy possibly leading to a decline in her quality of life. During a review of the facility's policy and procedures (P&P) titled "Baseline Care Plan," revised March 2023, the P&P indicated "The facility develops and implements a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards and quality of care ... The baseline care plan is based on the resident's admission orders, information available from the transferring provider, and discussion with the resident and resident representative, if available. Each resident's baseline care plan includes the instructions needed to provide effective and person-centered care for the immediate needs of the resident that meet professional standards of care ..."	F 655	**F656 Develop/Implement Comprehensive Care Plan. CFR(s): 483.21(b)(1)(3)** A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 73 no longer uses Cephalexin, Ciclopirox and Lotrimin cream. The interdisciplinary team developed and implemented a comprehensive person-centered care plan on 2/26/2025 for: 1. Resident 29's use of continuous positive airway pressure machine. 2. Resident 29's use of Humulin R insulin. 3. Resident 52's use of Insulin NPH. 4. Resident 97's preference for female caregivers. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents who use CPAP machines, Insulin to treat diabetes and residents with preferences for a specified gender of caregiver are potentially at risk. The MDS nurse/designee ran a report of residents with diabetes; The Director of Medical Records ran a report of residents who use CPAP machines on 3/20/2025; and	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 32 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	Social Services provided a list of residents with known preferences for a specified gender of caregivers on 3/18/2025. Copies of the audits were provided to the DON for further review and analysis. A total of 65 resident's records were analyzed. The IDT developed and implemented person centered care plans for 9 of 65 residents who required person-centered care plans for use of insulin, CPAP therapy or who had expressed preferences for specified gender of certified nurse assistant. Residents identified without interventions specific to CPAP, use of insulin and preferences for specified care givers. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Nursing/designee will re-educate the licensed nurses and IDT on or before 3/20/2025, re: the facility policy and procedure "Develop – Implement Comprehensive Care Plans," to ensure the development of a person-centered care plan is completed with person-specific interventions to address use of CPAP machines, use of insulin and known preference for a specific gender of certified nurse assistant.	

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F 656	Continued From page 33 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for: 1. Continuous Positive Airway Pressure (CPAP, a machine that uses air pressure to keep airways open during sleep) for one of three sampled residents (Resident 29) reviewed for respiratory care. 2. Humulin R (is a man-made insulin [a hormone that helps the body use blood sugar for energy] that is used to control high blood sugar) for one of two sampled residents (Resident 29) reviewed for insulin use. 3. Cephalexin (used to treat certain infections caused by bacteria such as pneumonia [lung infection] and other respiratory tract infections; and infections of the bone, skin, ears, , genital, and urinary tract), Ciclopirox (a topical antifungal medication that treats fungal infections of the skin and nails), and Lotrimin cream (an over-the-counter (OTC) antifungal cream that's applied to the skin to treat certain infections, such as ringworm and athlete's foot) for one of one sampled resident (Resident 73) reviewed for antibiotic (medicines that fight bacterial infections in people and animals) use. 4. Insulin NPH (a long-acting insulin that helps manage diabetes by lowering blood sugar levels)	F 656	The interdisciplinary team will review the care plans of newly admitted residents and residents with physician order changes from the prior business day during the clinical meeting to ensure care planning for the preference for the use of insulin, CPAP machines and known preferences for gender specific certified nurse aides are developed and implemented to ensure staff have guidelines to care for residents. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The interdisciplinary team, led by the MDS Coordinator, completes a discipline specific assessment of each resident at the time of admission to ensure person-centered care planning is present; to provide appropriate monitoring interventions. Care plans will be monitored and updated to reflect current interventions on admission, within 21 days, quarterly, annually, with significant change, as indicated. The MDS Coordinator/designee will report trends identified in the interdisciplinary team audits to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 656	Continued From page 34 for one of two sampled residents (Resident 52) reviewed for insulin use. The deficient practices above had the potential for residents to not receive necessary care and treatment. 5. Preference to be assigned only female certified nursing assistants (CNA) to provide care for one of nine sampled residents (Resident 97) reviewed during the Accidents care area. This deficient practice had the potential to result in failing to address Resident 97's needs and preferences negatively impacting the resident's physical, mental, and psychosocial well-being. Findings: 1.a. During a review of Resident 29's Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2025, with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), asthma (a chronic lung disease that makes breathing difficult), and methicillin resistant staphylococcus aureus (MRSA, a bacterium that does not respond to antibiotics) infection, type 2 diabetes mellitus (a disease that occurs when the blood glucose, also called blood sugar, is too high) with hyperglycemia (a condition in which the level of glucose in the blood is higher than normal), and cellulitis (a bacterial infection of the skin and tissue just beneath it) of right lower limb. During a review of Resident 29's History and Physical (H&P), dated 1/23/2025, the H&P	F 656		

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F 656	Continued From page 35 indicated the resident had the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 1/29/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities, like thinking, remembering, reasoning, and understanding, are fully functioning and not significantly impaired, allowing them to perform everyday tasks normally). During a review of Resident 29's Order Summary Report, dated 2/28/2025, the Order Summary Report did not indicate an order for CPAP. During an observation, interview and record review on 2/26/2025, at 8:29 a.m., with Registered Nurse (RN) 1, inside Resident 29's room, observed Resident 29 with a CPAP on. Reviewed Resident 29's Order Summary Report, Assessments, and Care Plans with RN 1. RN 1 stated there was no order, no assessment, and no care plan on the use of home CPAP in the facility. RN 1 stated the licensed staff should have created a care plan on the use of home CPAP in the facility to ensure its safe use. During an interview and record review on 2/26/2025, at 8:41 a.m., with Respiratory Therapist (RT) 1, reviewed Resident 29's Order Summary Report, Assessments, and Care Plans. RT 1 stated there was no order, no assessment, and no care plan on the use of home CPAP in the facility for Resident 29. RT 1 stated the licensed nurses were responsible for obtaining an order, performing an assessment on the safe use, and	F 656		

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F 656	Continued From page 36	F 656		

developing and implementing a care plan on the use of home CPAP in the facility of Resident 29. RT 1 stated the care plan is important to ensure the staff was using the machine safely and to communicate with other disciplines the interventions set in the use of the home CPAP in the facility.

During an interview on 2/28/2025, at 9:09 a.m., with the Director of Nursing (DON), the DON stated it was important to ensure there is a care plan on the use of home CPAP for Resident 29 to make sure they follow the indication and setting of the treatment per doctor's order to know the right way to use them and to monitor the effects of the home CPAP on the resident.

During a review of the facility's recent policy and procedure (P&P) titled "Develop-Implement Comprehensive Care Plans," last reviewed on 12/3/2024, the P&P indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.

1.b. During a review of Resident 29's MDS, dated 1/29/2025, the MDS indicated the resident was on a high-risk drug class hypoglycemic (drugs that help lower blood sugar levels) medication.

During a review of Resident 29's Order Summary Report, dated 1/28/2025, the Order Summary Report did not indicate an order for Humulin R Injection Solution 100 unit per milliliter (unit/ml, 100 units of insulin in each milliliter [mL]) (Insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 37	F 656		

Regular [Human]). Inject as per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 70 - 149 = 0 If blood sugar (BS) is less than 70 & awake, given orally (PO) juice. If unresponsive give Glucagon (a natural hormone in the body makes that works with other hormones to control glucose [sugar] levels in the blood) 1 mg intramuscular (IM, within a muscle), notify MD.; 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 4 units; 300 - 349 = 5 units; 350+ = 6 units Notify MD, subcutaneously before meals and at bedtime for Type 2 Diabetes Mellitus rotate injection site.

During a concurrent interview and record review on 2/28/2025, at 9:04 a.m., with the DON, reviewed Resident 29's Order Summary Report and Care Plan. The DON stated there was no care plan on the use of Humulin R on the resident's medical chart. The DON stated the licensed staff should have developed a care plan on the use of Humulin R for Resident 29 to ensure the licensed staff follow the indication and doses of the medication to ensure safe use. The DON stated the care plan serves as a communication to all health disciplines on what to watch for and what interventions were being implemented to the resident to deliver high-quality care.

During a review of the facility's recent policy and procedure (P&P) titled "Develop-Implement Comprehensive Care Plans," last reviewed on 12/3/2024, the P&P indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 656	Continued From page 38 resident's medical, physical, mental, and psychosocial needs. 2. During a review of Resident 73's Admission Record, the Admission Record indicated the facility admitted the resident on 9/24/2021, and readmitted the resident on 12/10/2022, with diagnoses including flaccid neuropathic bladder (when the bladder muscles are weak and cannot contract properly to empty urine because of nerve damage), chronic viral hepatitis C (a long-term liver infection that occurs when the body cannot get rid of the hepatitis virus), and acute respiratory failure (is a serious condition that makes it difficult to breathe on your own). During a review of Resident 73's H&P, dated 2/28/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 73's MDS, dated 11/28/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and was on a high-risk drug class antibiotic medication. During a review of Resident 73's Order Summary Report, the Order Summary Report indicated physician's orders dated: 2/20/2025 Cephalexin Tablet 500 milligrams (mg, a unit of weight). Give 1 tablet via gastrostomy tube (g-tube, a tube inserted through the wall of the abdomen directly into the stomach) four times a day for urinary tract infection (UTI, an infection in the bladder/urinary tract) for 10 days. 2/22/2025 Ciclopirox External Solution 8% (Ciclopirox). Apply to left toe nails topically (applied externally or on the surface) every day	F 656		

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F 656	Continued From page 39 and evening shift for onychomycosis (a medical term for a fungal infection of the nails) for 30 days. 2/22/2022 Ciclopirox External Solution 8% (Ciclopirox). Apply to right toe nails topically every day and evening shift for onychomycosis for 30 days. 2/22/2025 Lotrimin AF external cream 1% (Clotrimazole [Topical]). Apply to left hand ring finger topically every day and evening shift for dry scaly skin on left hand ring finger for 14 days. During a concurrent interview and record review on 2/26/2025, at 8:58 a.m., with RN 1, reviewed Resident 73's Order Summary Report and Care Plan. RN 1 stated there was no care plan developed and implemented on the use of Cephalexin, Ciclopirox, and Lotrimin AF external cream on the resident's medical chart. RN 1 stated a care plan should have been developed and implemented for Resident 73 by licensed nurses on its use to ensure the medications side effects were monitored and the plan on its use were communicated to all licensed staff to ensure safe use. During an interview on 2/28/2025, at 9:09 a.m., with the DON, the DON stated the staff should have developed and implemented a care plan on the use of Cephalexin, Ciclopirox, and Lotrimin AF external cream for Resident 73 to ensure the licensed staff follow the indication and doses of the medication to ensure safe use. The DON stated the care plan serves as a communication to all health disciplines on what to watch for and what interventions were being implemented to the resident to deliver high-quality care. During a review of the facility's recent P&P titled	F 656		

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F 656	Continued From page 40 "Develop-Implement Comprehensive Care Plans," last reviewed on 12/3/2024, the P&P indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. 3. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2024, with diagnoses including type 2 diabetes mellitus with hyperglycemia, and dysphagia (swallowing difficulties). During a review of Resident 52's H&P, dated 6/21/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 52's MDS, dated 12/17/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills (problems with a person's ability to think, learn, remember, use judgement, and make decisions) for daily decision making. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication including insulin. During a review of Resident 52's Order Summary Report, dated 2/22/2025, the Order Summary Report indicated an order for Insulin NPH (Human) (Isophane) Subcutaneous Suspension Pen-injector 100 unit/ml (Insulin NPH [Human] [Isophane]). Inject 18 unit subcutaneously (beneath, or under, all the layers of the skin) two	F 656		

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F 656	Continued From page 41 times a day for Diabetes/hyperglycemia. Rotate injection sites, hold for BS less than (<) 100. During a concurrent interview and record review on 2/28/2025, at 8:46 a.m., with the Medical Records Director (MRD), reviewed Resident 52's Order Summary Report and Care Plan. The MRD stated there was no care plan on the use of insulin NPH on Resident 52. The MRD stated it was important to have a care plan on the use of insulin NPH to ensure its safe use. The MRD stated the licensed staff should have developed and implemented a care plan on its use to make sure the interventions and goals were communicated to other healthcare disciplines. During an interview on 2/28/2025, at 9:09 a.m., with the DON, the DON stated the licensed staff should have developed a care plan on the use of insulin NPH on Resident 52 to make sure they follow the indication and doses of medication monitor the effects of these medications and to communicate the plan to all staff caring for the resident in the facility. During a review of the facility's recent policy and procedure (P&P) titled "Develop-Implement Comprehensive Care Plans," last reviewed on 12/3/2024, the P&P indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. 4. During a review of Resident 97's Admission Record, the Admission Record indicated the facility admitted the resident on 6/16/2023 and	F 656		

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F 656	Continued From page 42	F 656		

readmitted the resident on 5/28/2024 with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertensive heart disease without heart failure (high blood pressure that is present over a long time), and depression (persistent feelings of sadness and loss of interest that can interfere with daily living.

During a review of Resident 97's MDS, dated 11/28/2024, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required partial/moderate assistance from staff for oral and personal hygiene, toileting, bathing, and dressing.

During a review of Resident 97's Care Plan (CP) titled, "(Resident 97) prefers only Spanish-speaking CNAs" initiated 10/3/2024, the CP indicated to respect the resident's preferences.

During a concurrent observation and interview on 2/24/2025 at 10:30 a.m., with Resident 97 and CNA 3, Resident 97 sat in bed and stated she did not want any male CNAs to provide her care. CNA 3 stated the staff was aware Resident 97 did not want to have any male CNAs assigned to the resident.

During an interview on 2/25/2025 at 6:20 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 was providing care for Resident 97 and he was not aware the resident had any requests regarding male or female CNAs.

During an interview on 2/25/2025 at 6:25 a.m., with CNA 4, CNA 4 stated CNA 4 was not aware

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F 656	Continued From page 43 of any specific requests that Resident 97 had regarding CNA preferences. During an interview on 2/27/2025 at 6:47 a.m. with CNA 2, CNA 2 stated she had told the Director of Staff Development (DSD) and the licensed nurses that Resident 97 did not want any male CNAs to be assigned to provide Resident 97's care. During an interview on 2/27/2025 at 8:04 a.m., with Resident 97, Resident 97 lay in bed and stated Resident 97 had talked with the DSD and told the DSD that she did not want any male CNAs providing her care because she was afraid of men cleaning her. During a concurrent interview and record review on 2/27/2025 at 8:56 a.m., with the DSD, the DSD reviewed Resident 97's care plans. The DSD stated the DSD had known for about a year that Resident 97 did not want any male CNA's providing the resident's care. The DSD stated the DSD did not document or develop a care plan for Resident 97's preference for no male CNAs. During a concurrent interview and record review on 2/27/2025 at 8:56 a.m., with Minimum Data Set Nurse (MDSN) 2, MDSN 2 reviewed Resident 97's care plans and physician orders. MDSN 2 stated care plans are individualized for specific resident needs. MDSN 2 stated when a resident verbalizes a preference for no male CNAs to be assigned to provide care, there should be a care plan to reflect the preference to ensure that all facility staff are aware of the resident's preferences. MDSN 2 stated it was important to develop a CP for Resident 97's preference for no male CNAs to ensure no male	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 44 CNAs were assigned to care for Resident 97. During a concurrent interview and record review on 2/27/2025 at 9:10 a.m., with the DON, the DON reviewed Resident 97's CPs and facility policy regarding CPs. The DON stated she was not aware Resident 97 had a preference for no male CNAs to be assigned to provide care. The DON stated when Resident 97 verbalized a preference for only female CNAs, a CP should have been created but it was not. The DON stated the importance of CPs is a CP communicates with the interdisciplinary team the resident preferences to make sure the plan for the resident's care is what the resident wants. The DON stated when a CP for Resident 97's preference was not developed there was a potential that things could fall through the cracks and the needs of the resident would not be met. During a review of the facility recent P&P, last reviewed 12/3/2024, the P&P indicated the facility develops person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. Person-Centered Care: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. The comprehensive care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plans must be person-centered and reflect the resident's goals for admission and desired outcomes, interventions that reflect the resident's cultural preferences, values and practices. The	F 656		

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F 656	Continued From page 45 interdisciplinary team develops the care plan with corresponding interventions for care that is in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The facility must establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences.	F 656	**F657 CFR(s): 483.21(b)(3)(i)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The IDT met on 2/24/25 to review resident 73's use of physical restraints to review and revise the care plan to reduce the potential for unnecessary use of physical restraint. Evaluated all devices and family notified and wants the devices to continue due to benefits outweighing the risks. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** All residents are potentially affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The MDSN/designee will reeducate the nursing staff and IDT on completing a physical restraint/device assessment	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 657	Continued From page 46 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the interdisciplinary team (IDT - a group of people from different healthcare disciplines who work together to provide care for a resident) reviewed and revised the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessments for one of four sampled residents (Resident 73) reviewed for physical restraints (a device or technique that limits a person's movement or access to their body) by failing to conduct an interdisciplinary meeting to review and revise the care plan of the resident having multiple physical restraints. Resident 73 ' s care plan for physical restraints was last reviewed and revised on 8/19/2024. This deficient practice had the potential for unnecessary use of physical restraint that can result in physical and psychosocial decline of the resident. Findings: During a review of Resident 73 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 9/24/2021, and readmitted the resident on 12/10/2022, with diagnoses including spondylosis (a condition in which there is abnormal wear on the cartilage and	F 657	quarterly and with significant change; with revision of the car plan immediately following to reduce the potential for unnecessary use of physical restraint that can result in physical and psychosocial decline of the resident. The Director of Staff Development will orient new nursing personnel, at the time of hire and annually, on the facility policy and procedure, "Restraints," including completion of a quarterly restraint/device assessment with revision to the resident's care plan immediately following or as soon as practicable to support the residents psycho-social well-being. The Director of Nursing/designee will re-educate the licensed nurses and interdisciplinary team on or before 3/21/2025 re: the facility policy and procedure, "Care Plan," timing and revision with emphasis on completion of revised care plan interventions after each assessment including comprehensive and quarterly assessments or at the time of a significant change. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The IDT will monitor completion of	

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F 657	Continued From page 47 bones of the neck [cervical vertebrae]), osteoarthritis (a chronic disease that occurs when the cartilage in a joint breaks down), and anxiety disorder (a mental health condition that causes excessive and persistent fear and worry). During a review of Resident 73 ' s History and Physical (H&P), dated 2/28/2025, the H&P indicated the resident was on fall precautions and did not have the capacity to understand and make decisions. During a review of Resident 73 ' s Minimum Data Set (MDS - a resident assessment tool), dated 11/28/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and was dependent on mobility and activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had two falls since admission prior to assessment without injury and had a bed alarm (device that alerts caregivers when a resident tries to get out of bed). During a review of Resident 73 ' s Order Summary Report, the Order Summary Report indicated the following physician's orders dated: On 9/8/2022, bed alarm in bed, monitor for placement and function every (q) shift. Every Shift. On 12/14/2023, bilateral bed bolsters (prevents residents from rolling off a gurney or bed) while in bed. Every Shift for safety. On 1/26/2025, bilateral padded side rail (a bar that attaches to the side of a bed) every shift to prevent skin breakdown and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank	F 657	the resident's care plan following completion of the resident's quarterly assessments in accordance with the RAI schedule to to reduce the potential for the use of unnecessary restraints. The Director of Nursing will report trends identified during the IDT meetings and care plan review to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date 3/25/2025**	

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F 657	Continued From page 48 stares, and loss of consciousness) precautions (taking safety measures to prevent injury if someone has a seizure). On 1/16/2024, may have foot of the bed face the wall. Every shift. On 12/14/2023, resident may have bed against the wall with mattress placed upright with double mattress times (x) 2 on bedside floor. Every shift for safety. During a review of Resident 73 ' s Care Plan (CP) titled, "Disrupting Life Sustaining Medical Devices Use of device/s: Bilateral bed bolsters, bilateral floor mattress, pad alarm in bed, self-release belt while up on wheelchair, and abdominal binder for safety," was created on 8/24/2022 and last revised on 8/19/2024, the CP indicated a goal of the resident will have minimized complications related to device use, including contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), skin breakdown, altered mental status, isolation or withdrawal through review date. During a concurrent interview and record review, on 2/26/2025, at 8:08 a.m., with Registered Nurse (RN) 1, Resident 73 ' s Order Summary Report, Assessments, Informed Consents (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), and Care Plans were reviewed. RN 1 stated Resident 73 ' s CP titled "Disrupting Life Sustaining Medical Devices Use of device/s: Bilateral bed bolsters, bilateral floor mattress, pad alarm in bed, self-release belt while up on wheelchair, and abdominal binder for safety," was last revised on 8/19/2024.	F 657		

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F 657	Continued From page 49 During a concurrent interview and record review, on 2/26/2025, at 3:02 p.m., with Minimum Data Set Nurse (MDSN) 2, Resident 73 ' s Care Plans and IDTs were reviewed. MDSN 2 stated the CP titled, "Disrupting Life Sustaining Medical Devices Use of device/s: Bilateral bed bolsters, bilateral floor mattress, pad alarm in bed, self-release belt while up on wheelchair, abdominal binder for safety," was last revised on 8/19/2024. MDSN 2 stated the care plan should have been reviewed and revised every quarter. MDSN 2 stated there was no IDT done for the last quarter of 2024 discussing the revision of the care plan. MDSN 2 stated it was important to review and revise the care plans to help in reevaluating the intervention specifically restraint to minimize its use to prevent complications such as contractures, skin breakdown, altered mental status, isolation or withdrawal. During an interview, on 2/28/2025, at 9:20 a.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have reviewed and revised Resident 73 ' s care plan on the use of restraints quarterly to monitor for effectiveness of the care plan, its goals, and its interventions. The DON stated reviewing/revising the care plan helps in reevaluating the restraint to minimize its use. During a review of the facility ' s recent policy and procedure (P&P) titled, "Respect and Dignity - Physical Restraints," last reviewed on 12/3/2024, the P&P indicated the facility does not use physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident ' s medical symptoms. The IDT will provide on-going	F 657		

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F 657	Continued From page 50 documentation for the use of the physical restraint; and use the restraint for the least amount of time as possible, with ongoing re-evaluation. Falls generally do not constitute self-injurious behavior or a medial symptom that warrants the use of a physical restraint. During a review of the facility ' s recent P&P titled, "Documentation Policy," last reviewed on 12/3/2024, the P&P indicated in accordance with Centers for Medicare & Medicaid Services (CMS - a federal agency that manages health care programs in the United States) procedures for the Resident Assessment Instrument (RAI - standardized assessment tool used by nursing homes to create individualized care plans for residents), assessments for bowel and bladder, falls, chemical restraints (when a medication is used to intentionally calm or control someone's behavior), pressure sore risks (damage to an area of the skin caused by constant pressure on the area for a long time) and fall risks shall be completed using the Care Area Assessment (CAAs - an in-depth review of a resident's health to determine if they need care planning). CAAs may be used as frequently as indicated for assessments including but not limited to upon full MDS 3.0 assessments, quarterly reviews, or at any other time deemed appropriate by the IDT.	F 657	**F658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1. Resident 197 discharged on 3/4/25. Resident's MD declined to have thyroid hormone level checked after the discovery of missed doses. 2. MD was notified about the missed doses on 2/28/25 with no new orders. 3. The treatment nurse completed a skin assessment of Residents 69, 29 and 52 to identify signs or symptoms of skin breakdown in the area of routine injections. Residents 69, 29 and 52 did not have any signs or symptoms including discomfort in the area of injection sites. 4. Licensed Nurses are rotating injection sites for Resident 69, 29 and 52 and all residents who receive routine injections. 5. Licensed nurses are administering levothyroxine to Resident 197 in accordance with the physician order for administration. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;**	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		

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F 658	Continued From page 51 by: Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards by failing to: 1. Ensure three (3) of 3 sampled residents (Residents 65, 29, and 52) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) and anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) use had their subcutaneous (beneath the skin) insulin and heparin (an anticoagulant) administration sites rotated (a method to ensure repeated injections are not administered in the same area). The deficient practice had the potential to result in adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin and heparin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). 2. Ensure three doses of levothyroxine was administered as ordered by the physician for one of one sampled residents (Resident 197). This deficient practice had the potential to result in adverse effects (unwanted, unintended result) and serious health complications such as heart problems and impaired cognitive function. Cross reference F760 Findings:	F 658	Residents receiving routine injections in the same injection sites and who are not administered medications per physician order are potentially affected. The Director of Nurses/designee audited residents who receive routine injections 2/15-2025 through 2/25/2025 to identify other residents who may be affected by the facility practice. The Director of Nursing audited residents who receive Levothyroxine on 3/21/2025 to identify residents who did not receive the medication. A total of 19 residents receive Levothyroxine. 19 of 19 resident records accurately reflect doses remaining indicating residents received their medication. Resident injection sites were rotated; and no other residents were identified as affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development/designee will re-educate the licensed nurses re: the facility policy and procedure, "Diabetes Management," with emphasis on rotation of injection sites to avoid tissue damage from repeated injections on or before 3/21/2025.	

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F 658	Continued From page 52 a. During a review of Resident 65's Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/8/2021 and readmitted Resident 65 on 1/10/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin, and generalized muscle weakness. During a review of Resident 65's History and Physical (H&P) dated 1/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/17/2025, the MDS indicated Resident 65 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required partial to moderate a12ssistance with toileting hygiene, bathing, and lower body dressing; substantial to maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 65 received insulin. During a review of Resident 65's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 1/28/2025: - Insulin lispro injection solution (a short acting insulin)100 unit per milliliter (unit/ml) inject subcutaneously before meals and at bedtime for DM 2. Fingerstick blood sugar (FSBS - most common type of blood sugar monitoring) using lancets (a small needle) and test strips. Rotate injection site. Inject as per sliding scale	F 658	The DSD/designee will complete weekly audits of residents receiving subcutaneous injections to ensure licensed nurses are rotating injection sites routinely to ensure residents do not experience tissue damage to the extent possible. The DSD/designee will run an injection administration audit through PCC weekly to audit . Concerns identified will be reported to the Director of Nursing for further review, analysis, and follow-up. The Director of Staff Development will re-educate licensed nurses on the facility policy and procedure, Physician Orders," with emphasis on following physician orders including ordered time and frequency of administration on or before 3/21/2025. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Consultant Pharmacist monitors licensed nurses' proper administration of medication during routine facility audits and reports the findings to the QAA Committee, at a minimum quarterly for the purpose of process improvement. The Director of Nursing will monitor the DSD audits of resident subcutaneous injection sites by licensed nurses to ensure sites are rotated to mitigate tissue damage to the extent possible and to identify continued compliance or the need for further education or progressive disciplinary action through use of the injection administration audit on PCC.	

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F 658	Continued From page 53 (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 70 - 149 = 0 units; if BS less than (<) 70 and awake give juice; if unresponsive, give Glucagon (a hormone that raises blood sugar) 1 milligram (mg - a unit of measurement) intramuscularly (IM - inject into the muscle) and notify physician (MD); 150 - 199 = 4 units; 200 - 249 = 8 units; 250 - 299 = 12 units; 300 - 349 = 16 units; 350 plus = 20 units and notify MD. During a review of Resident 65's care plan (CP) titled "Risk for hypoglycemia (low blood sugar)/hyperglycemia (high blood sugar) related to diagnosis of DM 2" initiated on 1/13/2025 and last revised on 1/24/2025, the CP indicated to administer insulin lispro injection as ordered per sliding scale as one of the interventions to minimize complications related to DM 2. During a concurrent interview and record review on 2/27/2025 at 12:22 p.m., Resident 65's physician's orders, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) and Location of Administration Report for 2/2025 were reviewed with Licensed Vocational Nurse 3 (LVN 3). LVN 3 stated Resident 65 had a physician's order for insulin lispro which was administered as follows: - Insulin lispro injection solution 100 unit/ml: 2/02/25 10:19 p.m. subcutaneously abdomen - left lower quadrant (LLQ) 2/03/25 4:29 p.m. subcutaneously abdomen - LLQ 2/03/25 11:31 subcutaneously abdomen - LLQ 2/06/25 4:54 p.m. subcutaneously abdomen - right lower quadrant (RLQ)	F 658	The Director of Medical records/designee will audit the administration times of residents with Levothyroxine orders to ensure residents receive medication during acceptable timeframe for medication administration, monthly. Results of the medication administration audit will be given to the Director of Nursing for further review, analysis and follow-up as indicated. Compliance concerns identified will be corrected immediately and reported to the Director of Nursing for further corrective action as indicated. Trends identified in the injection site rotation audits will be reported by the Director of Staff Development to the Quality Assurance committee during the quarterly QA&A meeting for the purpose of process improvement changes to ensure continued compliance with this plan of correction/. **Allegation of Compliance Date 3/25/2025**	

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F 658	Continued From page 54 2/06/25 8:02 p.m. subcutaneously abdomen - RLQ 2/08/25 12:25 p.m. subcutaneously abdomen - LLQ 2/08/25 4:08 p.m. subcutaneously abdomen - LLQ 2/12/25 8:26 p.m. subcutaneously abdomen - RLQ 2/13/25 5:59 a.m. subcutaneously abdomen - RLQ 2/15/25 11:43 a.m. subcutaneously abdomen - LLQ 2/15/25 5:26 p.m. subcutaneously abdomen - LLQ LVN 3 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. LVN 3 stated Resident 65's MAR indicated the insulin administration sites were not rotated although, there was a physician's order to rotate injection sites. LVN 3 stated Resident 65's insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident's skin. During an interview on 2/28/025 at 1 p.m. Resident 65's physician's orders, MAR Location of Administration Report for 2/2025 was reviewed with the Director of Nursing (DON). The DON stated the location of administration sites for Resident 65's insulin were not rotated. The DON stated the charge nurses (CN) are supposed to rotate insulin administration sites according to standards of practice, as indicated in the manufacturer's guideline, and physician's order. The DON stated Resident 65 had a physician's order to rotate injection sites. The DON stated Resident 65's administration sites for insulin	F 658		

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F 658	Continued From page 55 should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. During a review of the facility provided undated, manufacturer's guideline for insulin lispro, the manufacturer's guideline indicated: - Change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. - Choose your injection site: insulin lispro is injected under the skin of your stomach area, buttocks, upper legs or upper arms. During a review of the facility's recent policy and procedure titled "Insulin Administration," last reviewed on 12/3/2024, the P&P indicated the injection sites should be rotated to reduce the risk of damaging the skin tissue. b. During a review of Resident 29's Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2025, with diagnoses including type 2 diabetes mellitus (a disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar [glucose] levels to be abnormally high), peripheral vascular disease (the reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), and atherosclerotic heart disease	F 658		

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F 658	Continued From page 56 (the buildup of fats, cholesterol and other substances in and on the artery walls). During a review of Resident 29's History and Physical (H&P), dated 1/23/2025, the H&P indicated the resident was on deep vein thrombosis (DVT, a blood clot in a vein deep in the body, usually in the leg) prophylaxis (an attempt to prevent disease) of heparin subcutaneous (sq, beneath, or under, all the layers of the skin) and had the ability to make self-understood and understand others. During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 1/29/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (person's cognitive abilities like memory, understanding, problem-solving etc. are working usually in all fundamental ways). The MDS indicated the resident was on an anticoagulant and hypoglycemic (a class of drugs that help lower blood sugar levels) medications. During a review of Resident 29's Order Summary Report, the Order Summary Report indicated an order for: 1/22/2025 Heparin Sodium (Porcine) Injection Solution 5000 unit per milliliters (unit [s an amount approximately equivalent to 0.002 mg of pure heparin]/ml [a unit of volume]) (Heparin Sodium (Porcine). Inject one milliliter subcutaneously three times a day for DVT prophylaxis and rotate injection sites. 1/22/2025 Heparin: Monitor for signs and symptoms of bleeding (abnormal or unexplained bruising, petechiae (small red or purple spots on the skin or inside the mouth that are caused by	F 658		

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 658	Continued From page 57 broken blood vessels), internal bleeding, nosebleeds, bleeding gums, abnormal bleeding) by (+)YES or(-)NO. Notify MD if (+). Every shift. 1/27/2024 Humulin R Injection Solution 100 unit/ml (Insulin Regular [Human]). Inject as per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal.): if 70 - 149 = 0, If blood sugar (BS) is less than 70 & awake, given orally (PO) juice. If unresponsive give Glucagon (a hormone that raises blood sugar [glucose]) 1 milligram (mg, a unit of weight) intramuscular (IM, within or into the muscle), notify MD.; 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 4 units; 300 - 349 = 5 units; 350+ = 6 units. Notify MD, subcutaneously before meals and at bedtime for Type 2 diabetes mellitus rotate injection site. During a review of Resident 29's Location of Administration Report of Humulin R and Heparin Sodium for 1/2025 to 2/2025, the Location of Administration Report indicated Heparin Sodium (Porcine) Injection Solution 5000 unit/ml was administered subcutaneously on: 1/24/2025 at 9:03 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 1/25/2025 at 6:37 a.m. on the Abdomen - LLQ And Humulin R Injection Solution 100 unit/ml was administered subcutaneously on: 1/29/2025 at 5:33 a.m. on the Abdomen - LLQ 1/29/2025 at 12:23 p.m. on the Abdomen - LLQ 2/14/2025 at 8:22 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 2/15/2025 at 8:46 p.m. on the Abdomen - LUQ During a concurrent interview and record review on 2/26/2025, at 8:47 a.m., with Registered Nurse (RN) 1, Resident 29's Location of Administration Report for Humulin R and Heparin Sodium for	F 658		

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F 658	Continued From page 58 1/2025 to 2/2025. RN 1 stated there were multiple instances where the licensed staff did not rotate the subcutaneous administration of heparin and Humulin R on the resident. RN 1 stated it was important to rotate heparin and Humulin R administration sites to prevent excessive bruising and lipodystrophy on residents. During an interview on 2/28/2025, at 9:04 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated Humulin R and heparin subcutaneous administration sites of Resident 29 to prevent adipose tissue (a connective tissue that extends throughout your body) buildup on the frequented site, discoloration, and hardening of the skin which can affect absorption of the medication. The DON added there was no reason for the licensed staff to repeat administration sites as it appears on the electronic healthcare record where the last subcutaneous administration of heparin and Humulin R was given. During a review of the facility's recent P&P titled "Insulin Administration," last reviewed on 12/3/2024, the P&P indicated the injection sites should be rotated to reduce the risk of damaging the skin tissue. During a review of the facility-provided Highlights of Prescribing Information on the use of Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982, the Highlights of Prescribing Information indicated subcutaneous injection: inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.	F 658		

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F 658	Continued From page 59 During a review of the facility-provided Highlights of prescribing Information on the use of Heparin Sodium Injection, USP for intravenous or subcutaneous use, with initial U.S. approval in 2009, the Highlights of Prescribing Information indicated under method of administration for deep subcutaneous (intrafat) injection, a different site should be used for each injection to prevent the development of massive hematoma. c. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2024, with diagnoses including type 2 diabetes mellitus, gastro-esophageal reflux disease (GERD, a condition where stomach acid flows into the esophagus), and dysphagia (swallowing difficulties). During a review of Resident 52's H&P, dated 6/21/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 52's MDS, dated 12/17/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills (a condition that makes it difficult for someone to think, learn, remember, and make decisions) for daily decision making. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 52's Order Summary Report, dated 2/22/2025, the Order Summary Report indicated an order for Insulin NPH (Human) (Isophane) Subcutaneous Suspension	F 658		

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F 658	Continued From page 60 Pen-injector 100 unit/ml (Insulin NPH [Human] [Isophane]), the report indicated to inject 18 units subcutaneously two times a day for diabetes/hyperglycemia (a condition in which there is too much glucose in the blood, also known as high blood sugar). Rotate injection sites and hold for blood sugar (BS) less than (<) 100. During a review of Resident 52's Location of Administration Report of Insulin NPH (Isophane) for 1/2025 to 2/2025, the Location of Administration Report indicated Insulin NPH (Isophane) Subcutaneous Suspension Pen-Injector 100 unit/ml was administered on: 1/5/2025 at 5:10 a.m. on the Abdomen - LLQ 1/5/2025 at 6:04 p.m. on the Abdomen - LLQ 1/19/2025 at 5:11 a.m. on the Abdomen - LLQ 1/19/2025 at 5:05 p.m. on the Abdomen - LLQ 2/7/2025 at 5:08 p.m. on the Abdomen - Right Lower Quadrant (RLQ) 2/8/2025 at 6:55 a.m. on the Abdomen - RLQ During a concurrent interview and record review on 2/26/2025, at 8:55 a.m., with RN 1, reviewed Resident 52's Location of Administration Report for Insulin NPH (Isophane) for 1/2025 to 2/2025. RN 1 stated there were multiple instances where the licensed staff did not rotate the subcutaneous administration of Insulin NPH (Isophane) on the resident. RN 1 stated it was important to rotate Insulin NPH (Isophane) administration sites to prevent excessive bruising and lipodystrophy on residents. During an interview on 2/28/2025, at 9:04 a.m., with the DON, the DON stated the licensed staff should have rotated Insulin NPH (Isophane) subcutaneous administration sites of Resident 52	F 658		

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F 658	Continued From page 61 to prevent adipose tissue buildup on the frequented site, discoloration and hardening of the skin which can affect absorption of the medication. The DON added there was no reason for the licensed staff to repeat administration sites as it appears on the electronic healthcare record where the last subcutaneous administration of Insulin NPH (Isophane) was given. During a review of the facility's recent P&P titled "Insulin Administration," last reviewed on 12/3/2024, the P&P indicated the injection sites should be rotated to reduce the risk of damaging the skin tissue. During a review of the facility-provided Consumer Information on the use of Humulin N vials insulin isophane, human biosynthetic (rDNA origin), suspension for injection, 100 unis/mL, the Consumer Information indicated to avoid tissue damage (skin thinning, skin thickening, or skin lumps), always change the site for each injection by at least 1.5 cm (0.5 inches) from the previous site, rotating sites of the body so that the same site is not used more than approximately once a month. Do not inject into pits (depressions), thickened skin or lumps. d. During a review of Resident 197's Admission Record, the Admission record indicated the resident was admitted on 2/17/2025 with diagnoses that included the presence of a left artificial hip joint, hypertensive heart disease (high blood pressure), and hypothyroidism (underactive thyroid, happens when your thyroid gland doesn't make enough thyroid hormones to meet your body's needs). During a review of Resident 197's physician	F 658		

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F 658	Continued From page 62 order, dated 2/17/2025, indicated levothyroxine sodium oral tablet 75 micrograms (mcg-a unit of measurement) give one tablet by mouth one time a day for hypothyroidism. During a review of Resident 197's History and Physical, dated 2/18/2025, the H & P indicated the resident had the capacity to understand and make decisions. During a review of Resident 197's Care Plan Report, dated 2/18/2025, the care plan report indicated Resident 197 has hypothyroidism and required daily thyroid replacement. The Care Plan Report included interventions to administer thyroid replacement therapy as ordered and to monitor or document side effects and effectiveness done by the licensed nurses. During an interview on 2/24/2025 at 10:18 a.m. with Resident 197, Resident 197 stated she has been here since 2/17/2025 and she has only received her thyroid medication only two to three times this week. Resident 197 stated she has not received her thyroid medication this morning. During a concurrent observation and interview on 2/27/2025 at 6:23 a.m. with Licensed Vocational Nurse (LVN) 1, while in Nursing Station 1, Resident 197's levothyroxine bubble pack was inside the medication cart. LVN 1 stated the levothyroxine 75 mcg tablet bubble pack was filled on 2/17/2025 with a total of five (5) doses/tablets were administered. LVN 1 stated he has not administered today's dose yet because the resident prefers to receive it at 7 a.m. During a concurrent interview and record review	F 658		

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F 658	Continued From page 63 on 2/28/2025 at 7:17 a.m. with LVN 1, Resident 197's Medication Administration Record (MAR), dated 2/1/2025 - 2/28/2025 was reviewed. The MAR indicated, a total of 10 doses of levothyroxine were administered from 2/18/2025 to 2/28/2025. LVN 1 stated, there was a total of 15 doses in the bubble pack and eight tablets were still in the bubble pack. LVN 1 stated there were three (3) tablets that were not administered. LVN 1 stated when Resident 197's levothyroxine are not administered the resident could have confusion. During an interview on 2/28/2025 at 8:47 a.m., the Director of Nursing (DON) stated Resident 197's medication should be administered as ordered and are given to treat specific diseases and monitored. The DON stated when medication is not administered it could affect Resident 197's thyroid functioning. The DON stated LVN 1 should call the doctor and family/representative informing them of what happened. The DON stated if the doctor will order a thyroid test the licensed nurse will carry out the order and monitor the resident for any changes. The DON stated this is a medication error and entails a change in condition. During a review of the facility's policy and procedure (P&P) titled, "Medication Errors," last reviewed on 12/3/2024, the P&P indicated a medication error is "The observed or identified preparation or administration of medications or biologicals which is not in accordance with: a. The prescriber's order ... Procedure: 1. When a medication reaches a resident in error, the facility should ... b. Notify the resident's representative and the Physician/Prescriber to obtain further instructions and/or orders. c. Facility staff should	F 658		

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F 658	Continued From page 64 monitor the resident in accordance with Physician's/Prescriber's instructions.	F 658	**F677** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** CNA 1 received one to one re-education regarding grooming and personal hygiene including cleaning the overbed table before and after placing washcloths onto it, Hand hygiene prior to and following providing grooming assistance o the residents and removing gloves prior to leaving the room to reduce the potential adversely affecting Residents' psychosocial well-being. Certified Nurse assistants are performing hand hygiene prior to donning and following doffing of gloves. Resident 65 is receiving grooming care in a manner that promotes his psychosocial well-being. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** All residents are potentially affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The DSD/designee will re-educate nursing staff on the facility's policy Activity of Daily Living with emphasis on hand hygiene prior to and after	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide necessary services to maintain good grooming and personal hygiene for one (1) of 1 sampled resident (Resident 65) reviewed for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) by failing to provide proper perineal (involves cleaning the private areas of a resident) care to the resident per facility policy and procedure (P&P). This deficient practice had the potential to result in a negative impact on Resident 65's psychosocial wellbeing. Cross-reference F697 and F880. Findings: During a review of Resident 65 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/8/2021 and readmitted in the facility on 1/10/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin (a	F 677		

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F 677	Continued From page 65 hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication), and generalized muscle weakness. During a review of Resident 65 ' s History and Physical (H&P), dated 1/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 65 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required partial/moderate assistance with toileting hygiene, bathing, and lower body dressing; substantial/maximal assistance from staff with all other ADLs. During a review of Resident 65 ' s care plan (CP) titled, "ADL: Resident 65 requires assistance with personal hygiene and toilet use," initiated on 1/12/2025 and last revised on 1/24/2025, the CP indicated to assist resident with toileting needs and maintaining good personal hygiene every shift and as needed as a few of the interventions to increase ADL participation and minimize functional decline. During an observation, on 2/24/2025, at 10:21 a.m., inside Resident 65 ' s room, Certified Nursing Assistant (CNA) 1 put on gloves without performing hand hygiene and grabbed three (3) wash cloths inside a plastic bag on top of Resident 65 ' s bed. CNA 1 went to the bathroom, wet the washcloths, and started wiping Resident 65 ' s eyes from inside corner to outer corner with 1 wash cloth, placed the 3 washcloths on top of	F 677	glove use, sanitizing the overbed table before and after use and not exiting the resident's room with gloves on 3/20/25 The DSD orients all nursing employees at the time of hire, annually and as needed regarding the facility's Activities of Daily Living responsibilities including providing grooming care with hand washing. proper glove use, and removing gloves prior to exiting the residents' rooms. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Staff Development will randomly assess certified nurse aide grooming skills through the day when on shift to ensure grooming assistance is provided in a manner that supports the resident's psychosocial well-being. The Infection Prevention will monitor certified nurse aides infection control practices including donning and doffing gloves when required, removing gloves prior to exiting a resident's room following care and cleaning and sanitizing overbed tables when used. The Director of Activities will ask residents if there are any concerns related to nursing care during the resident council meeting to identify any non-compliance with grooming. The Director of Staff Development/designee will report significant trends identified with resident grooming concerns, hand washing and cleaning and sanitizing	

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F 677	Continued From page 66 the overbed table that was not cleaned or sanitized, and left the room without removing her gloves. During a follow up concurrent observation and interview, on 2/24/2025, at 10:27 a.m., inside Resident 65 ' s room, with CNA 1, CNA 1, without performing hand hygiene, put on gloves, removed Resident 65 ' s incontinence briefs, and started providing ADL care to Resident 65 using the washcloths that were placed on top of the overbed table. CNA 1 wiped Resident 65 ' s perineal area with the washcloth that was placed on top of the overbed table. Resident 65 stated the washcloth was cold and CNA 1 proceeded to continue with placing a clean incontinence brief on the resident. During an interview, on 2/24/2025, at 3:21 p.m., with CNA 1, CNA 1 stated when providing perineal care to residents and changing their incontinence briefs, the staff are supposed to wash the hands or use hand sanitizer prior to putting on gloves, use 1 basin for soap and water, 1 basin for water to rinse off the soap, clean the table, have the resident check the water temperature, wipe the resident ' s perineal area using washcloth with soapy water with 1 stroke for each clean side of the washcloth, rinse with a washcloth with water and pat dry. CNA 1 stated she did not follow the steps in providing proper perineal care to the resident and was unable to tell the reason why. CNA 1 stated she should have followed the steps in providing proper perineal care to Resident 65. CNA 1 stated not providing the proper perineal care can make Resident 65 not feel clean and placed the resident at risk for getting an infection.	F 677	overbed tables during use for cares to resident altercations to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025	

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F 677	Continued From page 67 During an interview, on 2/28/2025, at 9:06 a.m., with the Director of Staff Development (DSD), the DSD stated the CNAs are supposed to clean the overbed table first prior to placing the washcloths and basins, use 1 basin for the soapy water, 1 basin for water to rinse the soap, washcloths, perform hand hygiene and put on gloves prior to providing ADL care to residents. The DSD stated for female residents, the CNAs are supposed to wash the perineal area with soapy washcloth, rinse the area using a clean washcloth, and pat dry the area using a clean washcloth from front to back and using the clean area of the washcloth for each stroke. The DSD stated CNA 1 should have followed the proper steps in providing perineal care to Resident 65 so the resident would feel clean and prevent the risk of infection. During a concurrent interview and record review, on 2/28/2025, at 1:00 p.m., with the Director of Nursing (DON), the facility ' s P&P titled, "Perineal Care," last reviewed on 12/3/2024, was reviewed. The DON stated the P&P indicated the proper steps of perineal care by performing hand hygiene, explain procedure to the resident, prepare equipment such as washbasins, soap, washcloths, gloves, and overbed table protector. The DON stated the P&P further indicated the proper steps in washing the pubic area (refers to the lower part of the abdomen, just above the genitals) for female residents is to wash the perineal area with soapy washcloth, rinse the area using a clean washcloth, and pat dry the area using a clean washcloth from front to back and using the clean area of the washcloth for each stroke. The DON stated CNA 1 should have should have followed the proper steps in providing perineal care to Resident 65 so the resident would feel clean and prevent the risk of	F 677		

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F 677	Continued From page 68 infection due to not providing proper perineal care to the resident. The DON stated it can affect Resident 65 ' s dignity, quality of life, and self-esteem. During a review of the facility ' s P&P titled, "ADL Care Provided for Dependent Residents," last reviewed on 12/3/2024, the P&P indicated a resident who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, and personal an oral hygiene. During a review of the facility ' s P&P titled, "ADL Maintain Abilities," last reviewed 12/3/2024, the P&P indicated each resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living including hygiene, bathing, dressing, grooming, and oral care. During a review of the facility ' s P&P titled, "Dignity and Respect," last reviewed on 12/3/2024, the P&P indicated: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Procedures shall be explained before they are performed, and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings. During a review of the facility ' s P&P titled, "Perineal Care," last reviewed on 12/3/2024, the P&P indicated a purpose to maintain the cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown. The P&P further indicated the following procedure: Wash hands Explain procedure to resident	F 677		

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F 677	Continued From page 69 Prepare equipment: washbasin, soap, washcloths bath towel, bed protector or pad, gloves, overbed table protector Put on gloves Wash the pubic area for female residents: separate the labia (the folds of skin surrounding the vaginal opening). Wash with soapy washcloth, moving from front to back, on each side of the labia and in the using a clean area of the washcloth for each stroke; rinse the area moving from front to back using a clean of the washcloth for each stroke; dry the area moving from front to back using a blotting motion with towel Do not touch anything with soiled gloves after procedure such as curtain, side rails, clean linen, call bell, etc.) Put on clean gloves Clean and return all equipment to its proper place Place soiled linen in proper container Remove gloves Wash hands	F 677	**F684** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 197 discharged on 3/4/25. Resident's MD declined to have thyroid hormone level checked after the discovery of missed doses. MD was notified about the missed doses on 2/28/25 with no new orders. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** The Director of Nursing audited residents who receive Levothyroxine on 3/21/2025 to identify residents who did not receive the medication. A total of 19 residents receive Levothyroxine. 19 of 19 resident records accurately reflect doses remaining indicating residents received their medication. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development will re-educate licensed nurses on the facility policy and procedure, Physician Orders," with emphasis on following physician orders including ordered time and frequency of administration on or before 3/21/2025.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 197), reviewed under	F 684		

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F 684	Continued From page 70 General care area, received treatment and care in accordance with professional standards of practice, by failing to identify and assess Resident 197 who had a change in condition, and was not administered three doses of levothyroxine as ordered. This deficient practice had the potential to result in Resident 197 to go unmonitored for symptoms of hypothyroidism such as fatigue, heart problems, and impaired cognitive function. Findings: During a review of Resident 197 ' s Admission Record, the Admission Record indicated the resident was admitted on 2/17/2025 with diagnoses including presence of left artificial hip joint, hypertensive heart disease (high blood pressure), and hypothyroidism. During a review of Resident 197 ' s physician order, dated 2/17/2025, the physician order indicated levothyroxine sodium oral tablet 75 micrograms (mcg-a unit of measurement) give one tablet by mouth one time a day for hypothyroidism. During a review of Resident 197 ' s History and Physical (H&P), dated 2/18/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 197 ' s Care Plan Report, dated 2/18/2025, the Care Plan Report indicated the care plan focus indicated Resident 197 has hypothyroidism and required daily thyroid replacement. The Care Plan Report included interventions to give thyroid replacement therapy	F 684	**D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Consultant Pharmacist monitors licensed nurses' proper administration of medication during routine facility audits and reports the findings to the QAA Committee, at a minimum quarterly for the purpose of process improvement. The Director of Nursing will monitor the Director of Medical Record audits of resident medication, Levothyroxine, to ensure residents receive their medication in accordance with physician orders. The Director of Medical records/designee will audit the administration times of residents with Levothyroxine orders to ensure residents receive medication during acceptable timeframe for medication administration, monthly. Results of the medication administration audit will be given to the Director of Nursing for further review, analysis and follow-up as indicated. Compliance concerns identified will be corrected immediately and reported to the Director of Nursing for further corrective action as indicated. If the DON identifies residents who did not receive their Levothyroxine in accordance with physician orders, the DON will begin an investigation into the medication error as applicable, and identify the root cause of the variance to the	

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F 684	Continued From page 71 as ordered and to monitor or document for side effects and effectiveness done by the licensed nurses. During an interview on 2/24/2025 at 10:18 a.m. with Resident 197, Resident 197 stated she has been at the facility since 2/17/2025, and she has only received her thyroid medication only two to three times this week. Resident 197 stated she has not received her thyroid medication this morning. During a concurrent observation and interview on 2/27/2025 at 6:23 a.m. with Licensed Vocational Nurse (LVN) 1, in Nursing Station 1, Resident 197 ' s levothyroxine bubble pack inside the medication cart. LVN 1 stated the levothyroxine 75 mcg tablet bubble pack was filled on 2/17/2025 with a total of five (5) doses/tablets were administered. LVN 1 stated he has not administered today ' s dose yet because resident prefers to receive it at 7 a.m. During a concurrent interview and record review on 2/28/2025 at 7:17 a.m. with LVN 1, Resident 197 ' s Medication Administration Record (MAR), dated 2/1/2025 - 2/28/2025 was reviewed. The MAR indicated, a total of 10 doses of levothyroxine were administered from 2/18/2025 to 2/28/2025. LVN 1 stated, there was a total of 15 doses in the bubble pack and eight tablets were still in the bubble pack. LVN 1 stated there were three (3) tablets that were not administered. LVN 1 stated when Resident 197 ' s levothyroxine was not administered the resident could have confusion. During an interview on 2/28/2025 at 7:20 a.m. with LVN 1, LVN 1 stated he did not complete a	F 684	physician order to re-educate or discipline as determined. Trends identified in the administration of Levothyroxine and other medications will be reported by the Director of Staff Development to the Quality Assurance committee during the quarterly QA&A meeting for the purpose of process improvement changes to ensure continued compliance with this plan of correction. **Allegation of Compliance Date 3/25/2025**	

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F 684	Continued From page 72 change in condition and a progress note on 2/27/2025 on Resident 197 ' s missed doses of levothyroxine. LVN 1 stated he was not at fault because he administered all the medications when he was scheduled to work. LVN 1 stated if he created the change in condition and progress note would that mean that it was his fault. LVN 1 stated when a medication was not administered, he would inform the Director of Nursing (DON). LVN 1 stated he did not inform the DON on 2/27/2025 but he will inform the DON today, 2/28/2025. During an interview on 2/28/2025 at 8:47 a.m., with the Director of Nursing (DON), the DON stated Resident 197 ' s medication should be administered as ordered to treat specific diseases and should be monitored. The DON stated when medication is not administered it could affect Resident 197 ' s thyroid functioning. The DON stated LVN 1 should call the doctor and family/representative informing them of what happened. The DON stated LVN 1 did not inform her about Resident 197 ' s missed levothyroxine doses. The DON stated if the doctor will order a thyroid test the licensed nurse will carry out the order and monitor the resident for any changes. The DON stated this is a medication error and entails a change in condition. During an interview on 2/28/2025 at 1:18 p.m. with the Assistant Director of Nursing (ADON), the ADON stated he was only made aware today about Resident 197 ' s missed levothyroxine doses. The ADON stated the licensed nurse, Registered Nurse (RN) or LVN, can initiate the change in condition (COC) and progress notes and this should be done as soon as possible. The ADON stated an RN would then close the	F 684		

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F 684	Continued From page 73 resident ' s COC assessment. The ADON stated the purpose of initiating a COC and progress notes if to monitor Resident 197 for any adverse consequences. During a review of the facility ' s policy and procedure (P&P) titled, "Care and Services Interdisciplinary Team," last reviewed 12/3/2024, the P&P indicated "the licensed nurse/designee documents and notifies the resident ' s physician and responsible party of: Change in condition including progress and/or decline in physical or mental function." During a review of the facility ' s P&P titled, "Medication Errors," last reviewed 12/3/2024, the P&P indicated medication error is "The observed or identified preparation or administration of medications or biologicals which is not in accordance with: a. The prescriber ' s order ... Procedure: 1. When a medication reaches a resident in error, the facility should ... b. Notify the resident ' s representative and the Physician/Prescriber to obtain further instructions and/or orders. c. Facility staff should monitor the resident in accordance with Physician ' s/Prescriber ' s instructions.	F 684	**F689 Free of Accident Hazards Supervision/Devices CFR(s): 483.25(d)(1)(2)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1. The licensed nurse removed two tubes of triamcinolone acetonide from Resident 41's bedside table on 2/24/2025. 2. Resident 348's floor pad alarm was activated by a certified nurse assistant on 2/28/2025 3. Housekeeping cleaned the spill and placed a wet floor sign in the area of nine residents when fluids were identified on the floor 2/25/2025, to reduce the potential to result in falls resulting in injuries like fractures 4. Furniture in the rooms of Residents 34, 83 and 42 were removed from the floor pad mat to reduce the risk of injury from a fall on 2/28/2025. 5. The IDT completed a fall assessment for Resident 83 and reviewed and revised 2/24/25 care plan for injuries related to falling.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689	**B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents with the use of pad alarms, landing mats and medications left unattended at the bedside are potentially affected by the facility practice.	

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F 689	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards by failing to: 1. Ensure two tubes of triamcinolone acetonide cream (a topical medication used to treat skin conditions) were not left unattended at the resident ' s bedside for one of nine sampled residents (Resident 41) reviewed under the Accidents care area. This deficient practice had the potential to result in the resident ' s self-administration of medication which could potentially result in adverse reactions like itchiness, rashes, and illness from accidental ingestion of topical medications. 2. Ensure the floor pad alarm (alerting device used to monitor a resident's movement) was activated when the resident moved in a certain way for one of nine sampled residents (Resident 348) reviewed under the Accidents care area. 3. Ensure the hallway was free from liquid spills while residents were unattended by staff for one of nine sampled residents (Resident 66) reviewed under the Accidents care area. These deficient practices had the potential to result falls resulting in injuries like fractures (broken bones) and lacerations. 4. Ensure resident fall mats (a cushioned mat that reduces the risk of injury from a fall) did not have a furniture or equipment on top of them for three	F 689	The Director of Nursing/designee audited the rooms of residents who use alarms and landing mats to ensure alarms were turned to the on position when the resident is using the device and to ensure furniture or other items are not obstructing the landing strip on 2/27/2025. 5 other patients were affected and the furniture was moved so that is was not obstructing the mat on 2/27/2025. The Charge Nurse audited all resident rooms to identify residents with unattended medications at the bedside on 2/24/2025. No other affected residents were found. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development will re-educate the nursing staff on 3/18/25 the facility policy and procedure, "Accidents and Fall Management", with emphasis on the requirements to: 1. Medications should not be left at the bedside in the absence of residents assessed and approved for self administration of medications. 2. Floor pad alarms should be in the on position when the resident is in bed. 3. Liquids on the floor are everyone's responsibility and should be cleaned by the appropriate personnel when seen and a wet floor	

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F 689	Continued From page 75 of nine sampled residents (Resident 34, 83, and 42) reviewed during the Accidents care area. This deficient practice increases the risk of injury when the resident slips, trips, and falls by hitting the hard surface of the equipment or furniture that is on top of the fall mat. 5. Complete the post fall monitoring per facility policy and procedure for one of nine sampled residents (Resident 83) reviewed during the Accidents care area. This deficient practice had the potential to result in resident injury from falls. Findings: a. During a review of Resident 41 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/17/2024 with diagnoses that included fracture (break in the bone) of shaft of left femur (the long portion of the thigh bone) and unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life. During a review of Resident 41 ' s Self Administration of Medication Assessment form, dated 12/17/2024, the form indicated the resident did not express a desire to self-administer medications and a self-administration evaluation and determination was not completed. During a review of Resident 41 ' s Minimum Data Set (MDS - resident assessment tool) dated 12/24/2024, the MDS indicated the resident was able to understand others and was able to make	F 689	sign should be placed over the wet area. 4. Furniture should be clear of fall mats to reduce the potential for the furniture to obstruct a resident's fall. 5. Post fall assessments should be completed following each episode of falling for residents. The Director of Staff Development will orient new nursing personnel, at the time of hire and annually, on the facility policy and procedure, "Accident Management" with emphasis on resident monitoring, activating alarms, not leaving medications at bedside and attending to spills on the floor for safety. The Registered Nurse Supervisors will complete walking rounds during their assigned shifts at the beginning of their shifts to ensure resident interventions to reduce falls and/or reduce injury with falling are implemented including being activated and without furniture or other obstruction to mats; and to identify if residents have medications at their bedside. The Administrator revised the Management Team's rounding tool to include identification of medications at the bedside and unsafe hazards including fluid on the floor, alarms not activated, landing strips with obstructions on them and medications at the bedside. Management team consists of all department heads with room rounds.	

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F 689	Continued From page 76 herself understood. The MDS further indicated the resident required substantial/maximal assistance from staff for toileting, bathing, dressing, personal hygiene, and mobility. During a review of Resident 41 ' s Change of Condition form, dated 1/27/2025, the form indicated the resident had a skin rash to the upper back. During a concurrent observation and interview on 2/24/2025 at 10:05 a.m., with Resident 41 and Visitor Care Giver (VCG) 1, Resident 41 sat in a wheelchair at the bedside. A tube of triamcinolone acetonide cream was observed on the resident ' s bed. Resident 41 stated she uses the cream because she has a rash. VCG 1 stated Resident 41 applies the cream herself and she keeps it at the bedside. During a concurrent observation and interview on 2/25/2025 at 9:03 a.m. with Certified Nursing Assistant (CNA) 5 and Family Member (FM) 1, while in Resident 41 ' s room, CNA 5 stated Resident 41 often complains of itchiness and kept a cream at the bedside to apply. FM 1 stated Resident 41 was prescribed a medication for a skin issue that the resident stored in a bin on the nightstand. Two tubes of triamcinolone acetonide cream were observed sitting in a bin on Resident 41 ' s nightstand. CNA 5 stated the triamcinolone acetonide cream was the cream the resident applied for itchiness. FM 1 was observed to place the two tubes of triamcinolone acetonide cream back in the open bin on the nightstand. CNA 5 was observed exiting Resident 41 ' s room and did not remove the triamcinolone acetonide cream.	F 689	**D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Management Team will monitor their assigned resident rooms five times weekly to ensure compliance with medications, landing mats, alarms and fluid spills for the safety of all residents. The DSD will complete safety rounds daily during routinely scheduled work hours to ensure resident safety interventions are implemented including proper functionality of pad alarms, placement of landing mats and no spills on the floors. Concerns identified will be corrected at the time of observation and reported to the Director of Nursing. The Director of Nursing will monitor the licensed nurses and certified nursing assistants' performance through direct observation, Department Manger audits and DSD rounds; and provide re-education or progressive disciplinary action as indicated. The Director of Medical Records/Designee will audit the nurses follow up charting daily after a fall. The Administrator will conduct routine rounds each day during routinely scheduled work hours, to ensure residents are supervised and safety interventions are activated, without obstructions and floor signs where spills have been cleaned. The DON/designee will report trends identified in resident care plan,	

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F 689	Continued From page 77 During an interview on 2/25/2025 at 9:20 a.m., with Licensed Vocational Nurse (LVN) 6, LVN 6 stated medications should not be stored at the bedside and all staff members know they must report any medication at the bedside so it can be removed. LVN 6 stated Resident 41 should not have triamcinolone acetonide cream at the bedside and the resident did not have an order for the cream. LVN 6 stated CNA 5 should have reported the medication at the bedside, but CNA 5 did not report it. LVN 6 stated it was important to have an order for medication because the physician must know what medication a resident is taking to ensure it is appropriate for the resident and administered per the physician ' s order. LVN 6 stated it was not safe for Resident 41 to store triamcinolone acetonide cream and self-administer the medication. LVN 6 stated she would remove the cream from Resident 41 ' s room. During an interview on 2/27/2025 at 11:33 a.m., with Treatment Nurse (TN) 1, TN 1 stated prescribed medications are only applied by the treatment nurse and should not be left unsecured at the bedside. TN 1 stated TN 1 was made aware that Resident 41 had triamcinolone acetonide cream and was self-administering the medication. TN 1 stated Resident 41 should not have had the medication at the bedside and the self-administration of triamcinolone acetonide cream may have potentially caused the resident to have an allergic reaction like itchiness. TN 1 stated when medication is left at the bedside there is also the potential that Resident 41 or another confused resident may ingest the medication causing an adverse reaction. During a follow up interview on 2/27/2025 at 2	F 689	assessment, supervision and safety intervention observations and audits to the Quality Assurance committee during the quarterly QA&A meeting for the purpose of process improvement changes to ensure continued compliance with this plan of correction. **Allegation of Compliance Date: 3/25/2025.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 689	Continued From page 78 p.m., with CNA 5, CNA 5 stated she left the triamcinolone acetonide cream in Resident 41 ' s room and did not notify any staff that it was there. CNA 5 stated it was a mistake to leave the cream in the room and she should have removed it and notified the nurse, but she did not. During a concurrent interview and record review on 2/28/2025 at 11 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding medication self-administration and resident supervision. The DON stated when a resident wants to self-administer medication the interdisciplinary team performs a safety evaluation, and if the resident is able to safely administer the medication, then the physician writes an order. The DON stated Resident 41 is not safe for the self-administration of medication. The DON stated CNA 5 should not have left the triamcinolone acetonide cream in Resident 41 ' s room without reporting it to the CN. The DON stated the facility policy was not followed when triamcinolone acetonide cream was left in Resident 41 ' s room and could have potentially resulted in residents ingesting the medication causing an adverse reaction like nausea, headaches, or diarrhea. During a review of the facility policy and procedure (P&P) titled, "Resident Self Administer Medications," last reviewed 12/3/2025, the P&P indicated the interdisciplinary team supports the right of each resident to self-administer medications when this practice is clinically appropriate. The interdisciplinary team evaluates each resident's ability to safely self-administer medications when the resident requests to exercise this right. A resident may only	F 689		

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F 689	Continued From page 79 self-administer medications after the IDT has determined which medications may be self-administered. During a review of the facility P&P titled, "Free of Accident Hazards/Supervision/ Devices," last reviewed 12/3/2025, the P&P indicated the facility provides an environment that is free from accident hazards over which the facility has control, and each resident receives adequate supervision to prevent avoidable accidents. An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. A facility with a commitment to safety acknowledges the high-risk nature of its population and setting; and engages all staff, residents and families in training on safety, and promotes ongoing discussions about safety with input from staff at all levels of the organization, as well as residents and families. All staff is involved in observing and identifying potential hazards in the environment. b. During a review of Resident 348 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 2/22/2025 with diagnoses that included sequelae of cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), dementia, and seizures (abnormal electrical activity in the brain). During a review of Resident 348 ' s Fall Risk Evaluation, dated 2/22/2025, the evaluation indicated the resident was disoriented, had a history of one to two falls in the past three months, had balance problems while standing/walking, and was a high risk for falls.	F 689		

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F 689	Continued From page 80 During a review of Resident 348 ' s Order Summary Report, the order summary report indicated an order for a floor alarm to alert the staff when the resident is trying get up in bed unassisted. Monitor placement and function every shift, dated 2/24/25. During a review of Resident 348 ' s History and Physical (H&P), dated 2/28/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a concurrent observation on 2/28/2025 at 8:55 a.m., Resident 348 sat in the bed in the low position. The resident ' s feet were on the left floor alarm pad and the floor alarm pad was not alarming. During a concurrent observation and interview on 2/28/2025 at 8:58 a.m. with Registered Nurse (RN) 2, RN 2 stated Resident 348 was a fall risk and had floor alarm pads to alert staff when the resident attempted to get up. While entering Resident 348 ' s room the resident ' s feet were observed on the alarm pad. The alarm was not sounding. RN 2 stated RN 2 had turned off the alarm when RN 2 was previously in the room. RN 2 turned on the floor alarm and the floor alarm sounded from the pressure of Resident 348 ' s feet. RN 2 stated she should not have turned off the alarm and left the resident unattended, but she did. RN 2 stated the alarm was important because the resident was a risk for falls. RN 2 stated when she turned off the alarm and left the resident unattended, it could have potentially resulted in the resident falling resulting in an injury.	F 689		

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F 689	Continued From page 81 During a concurrent interview and record review on 2/28/2025 at 11 a.m., with the DON, the DON reviewed the facility P&P regarding fall prevention and resident supervision. The DON stated a floor alarm should be on at all times to alert staff when a resident is attempting to get out of bed unassisted. The DON stated the facility policy was not followed when Resident 348 ' s floor alarm was not activated and could have potentially resulted in injury to the resident from a fall. During a review of the facility P&P titled, "Position Change Alarms-Safety," last reviewed 12/3/2025, the P&P indicated the facility takes steps to identify resident's risk for falls and implements approaches to address those risks in a manner that enables the resident to achieve or maintain his or her highest practicable physical, mental, and psychosocial well-being. Position Change Alarms are alerting devices intended to monitor a resident's movement and that emit an audible signal when the resident moves in a certain way. Each resident shall be evaluated on admission for risks related to falls and implements approaches to reduce or eliminate identified risks. During a review of the facility P&P titled, "Free of Accident Hazards/Supervision/ Devices," last reviewed 12/3/2025, the P&P indicated the facility provides an environment that is free from accident hazards over which the facility has control, and each resident receives adequate supervision and assistive devices for each resident to prevent avoidable accidents. An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the	F 689		

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F 689	Continued From page 82 likelihood of accidents. Hazards may include, but are not limited to, aspects of the physical plant, equipment, and devices that are disabled/removed. c. During a review of Resident 66 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/22/2022 and readmitted the resident on 5/2/2024 with diagnoses that included dementia, encephalopathy (an alteration in consciousness due to brain dysfunction), history of falling, and muscle weakness. During a review of Resident 66 ' s MDS, dated 1/26/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required supervision or touching assistance from staff for mobility during sitting to standing and required partial/moderate assistance from staff for transferring from the bed to chair and walking at least 10 feet once standing. During a review of Resident 66 ' s Care Plan (CP) titled, "(Resident 66) is at risk for recurrent falls and spontaneous injury related to confusion and forgetfulness, unaware of safety needs ..., history of falling, ..." initiated on 5/2/2024, the CP indicated a goal that the resident would remain free of injury from falls and interventions including providing a safe environment with even floors free from spills. During a concurrent observation and interview on 2/25/2025 at 12:55 p.m., Resident 66 was observed self-propelling in a wheelchair down the hallway toward Station 1. The resident was	F 689		

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F 689	Continued From page 83 unattended, and no staff were present. A large spill of liquid was observed on the floor near the medication cart directly to the left of Resident 66. Resident 66 stated she was looking for her family and wanted to leave. Resident 66 turned in the wheelchair and advanced the opposite direction toward the resident ' s room. During an observation and interview on 2/25/2025 with LVN 6, LVN 6 stated about five to six minutes prior, LVN 6 had spilled tube feeding formula (a liquid food administered through a tube in the stomach) on the floor. LVN 6 stated LVN 6 called for housekeeping to come clean the spill. LVN 6 stated LVN 6 left the spill unattended because a resident called for assistance and LVN 6 went to a resident ' s room. LVN 6 call for housekeeping assistance. During an interview on 2/27/2025 at 12:30 p.m. with the Housekeeping Supervisor (HS), the HS stated spills should be cleaned immediately because residents, staff, or visitors could slip and fall. The HS stated when a spill occurs, any staff can place a towel on the spill and call for housekeeping staff to disinfect. The HS stated LVN 6 should not have left a spill in the hallway when the housekeeping staff were delayed in responding to the call on 2/25/2025. During an interview on 2/28/2025 at 9 a.m., with RN 2, RN 2 stated when a spill occurs in the hallway, anyone can grab a towel and clean it up. RN 2 stated LVN 6 should not have left a spill unattended in the hallway, but she did. RN 2 stated when LVN 6 left the spill unattended in the hallway Resident 66 could have potentially stood up and slipped on the spill resulting in an injury like a broken bone.	F 689		

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F 689	Continued From page 84 During a review of the facility P&P titled, "Free of Accident Hazards/Supervision/ Devices," last reviewed 12/3/2025, the P&P indicated the facility provides an environment that is free from accident hazards over which the facility has control, and each resident receives adequate supervision to prevent avoidable accidents. An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. A facility with a commitment to safety acknowledges the high-risk nature of its population and setting. Effective Accident Management identifies environmental hazards, the resident's risk for an avoidable accident, and evaluates the resident's need for supervision. All staff is involved in observing and identifying potential hazards in the environment. Some factors that may result in resident falls include, but are not limited to, environmental hazards, wet floors. d. During a review of Resident 34's Admission Record, the Admission Record indicated the facility admitted the resident on 9/15/2018, and readmitted the resident on 4/19/2022, with diagnoses including hemiplegia (paralysis that affects only one side of your body) and hemiparesis (muscle weakness or partial paralysis that affects one side of the body) following cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked), and osteoarthritis (degenerative joint disease, in which the tissues in the joint break down over time) of left hip. During a review of Resident 34's H&P, dated 2/8/2024, the H&P indicated the resident had	F 689		

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F 689	Continued From page 85	F 689		

debility (a general state of weakness or feebleness that can affect a person's physical or mental state), logical thoughts (uses reasoning skills to objectively study any problem, which helps make a rational conclusion about how to proceed), and cooperative behavior.

During a review of Resident 34's MDS, dated 12/7/2024, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities, like thinking, remembering, understanding, and reasoning, are fully functional and working normally, with no significant impairments or decline in their cognitive skills). The MDS indicated the resident was dependent to requiring substantial to maximal assistance on mobility and activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).

During a review of Resident 34's CP indicating the resident is at risk for falls related to confusion, gait (a manner of walking or moving on foot)/balance problems, incontinence (the involuntary loss of bladder or bowel control), poor communication/ comprehension, and psychoactive drug (a chemical substance that changes how the brain functions, which can alter mood, perception, and behavior) use, last revised on 4/20/2022, the CP indicated an intervention to promote a safe environment with: (Example: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, personal items within reach).

During an observation on 2/24/2025, at 9:28 a.m., observed Resident 34's fall mat at the right side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 689	Continued From page 86 of the bed had an oxygen concentrator (a medical device that removes nitrogen from the air to deliver oxygen that's 85-95% pure) and a side table on top of them. During a concurrent observation and interview on 2/24/2025, at 9:39 a.m., with LVN 5, inside Resident 34's room, observed Resident 34's fall mat at the right side of the bed had an oxygen concentrator and a side table on top of them. LVN 5 stated there should be no furniture or medical equipment on top of the fall mat of Resident 34 because the resident can fall on them and cause falls with injury to the resident such as fractures (break in bone) and lacerations (cut refers to a skin). During an interview on 2/28/2025, at 9:16 a.m., with the DON, the DON stated the fall mat of Resident 34 should be clear of equipment or furniture on top of them to prevent falls with injury. The DON stated the resident could hit the medical equipment or furniture on top of the fall mat when they fall that can cause laceration or fracture on residents. During a review of the facility's recent P&P titled "Fall Management Program," last reviewed on 12/3/2024, the P&P indicated the facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls; and to provide an environment which remains as free from accident hazards as possible. During a review of the facility's recent P&P titled "Free of Accident Hazards/Supervision/Devices," last reviewed on 12/3/2024, the P&P indicated the facility provides an environment that is free from	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 689	Continued From page 87	F 689		

accident hazards over which the facility has control, and each resident receives adequate supervision and assistive devices for each resident to prevent avoidable accidents. All staff is involved in observing and identifying potential hazards in the environment. The facility makes reasonable efforts to identify the hazards and risk factors for each resident.
e. During a review of Resident 83's Admission Record, the Admission Record indicated the facility admitted the resident on 12/23/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), speech disturbances, and generalized muscle weakness.

During a review of Resident 83's History and Physical (H&P) dated 12/29/2024, the H&P indicated Resident 83 had the capacity to make decisions.

During a review of Resident 83's MDS, dated 12/30/2024, the MDS indicated Resident 83 had an intact cognition and required total assistance with sit to stand activities and transfers; partial/moderate assistance with eating, oral hygiene, and personal hygiene; substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).

During a review of Resident 83's fall risk assessment dated 12/23/2024, 1/21/2025, and 2/33/2025, the fall risk assessments indicated the resident was a high risk for falls.

During a review of Resident 83's Order Summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 689	Continued From page 88 Report, the Order Summary Report indicated a physician's order dated 1/29/2025 for landing mats to minimize injury every shift for safety. During a review of Resident 83's CP on risk for recurrent falls and spontaneous injury initiated on 5/18/2021 and last revised on 1/9/2025 and last revised on 2/24/2025, the CP indicated landing mat as one of the interventions to prevent falls. During a concurrent observation and interview on 2/24/2025 at 9:49 a.m. inside Resident 83's room, observed Resident 83's lading mat on the left side with the overbed table placed on top. During a concurrent observation and interview on 2/24/2025 at 9:56 a.m. inside Resident 83's room with LVN 4, LVN 4 stated Resident 83's overbed table was placed on top of the left landing mat. LVN 4 stated that the overbed table can be unstable if placed on top of the floor mat and possibly fall on the residents. LVN 4 stated the residents can lose balance and hit the overbed table when getting out of bed unassisted. LVN 4 stated the overbed table should have not been placed on top of Resident 83's floor mat as it placed the resident at risk for getting injured when Resident 83 lose balance while trying to get out of bed unassisted. During a concurrent interview and record review on 2/28/2025 at 1p.m., reviewed a photograph of Resident 83's floor mat dated 2/24/2024 at 9:56 a.m. with the DON, the DON stated Resident 83's overbed table was placed on top of the left floor mat. The DON stated there should always be no furniture or equipment on top of residents' floor mats for resident safety. The DON stated Resident 83's overbed should not have been	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 89	F 689		

placed on top of the floor mat to prevent injuries when Resident 83 tries to get out of bed unassisted which may lead to hospitalization.

During a review of the facility's recent P&P titled "Fall Management Program," last reviewed on 12/3/2023, the P&P indicated the facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls; and to provide an environment which remains as free from accident hazards as possible.

During a review of the facility's recent P&P titled "Free of Accident Hazards/Supervision/Devices," last reviewed on 12/3/2024, the P&P indicated the facility provides an environment that is free from accident hazards over which the facility has control, and each resident receives adequate supervision and assistive devices for each resident to prevent avoidable accidents. All staff is involved in observing and identifying potential hazards in the environment. The facility makes reasonable efforts to identify the hazards and risk factors for each resident.

f. During a review of Resident 42's Admission Record, the Admission Record indicated the facility admitted the resident on 12/30/2024 with diagnoses including malignant neoplasm of left female breast (abnormal growth of tissue that can spread to other parts of the body), difficulty in walking, and generalized muscle weakness.

During a review of Resident 42's History and Physical (H&P) dated 12/31/2024, the H&P indicated Resident 42 had the capacity to make decisions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 90 During a review of Resident 42's MDS, dated 1/5/2025, the MDS indicated Resident 42 had an intact cognition and required partial/moderate assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 42's fall risk assessment dated 12/30/2024, the fall risk assessment indicated the resident was a high risk for falls. During a review of Resident 42's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/30/2024 for landing mats to minimize injury. During a review of Resident 42's CP on risk for recurrent falls and spontaneous injury initiated on 12/31/2024 and last revised on 1/9/2025, the CP indicated landing mat as one of the interventions to prevent falls. During a concurrent observation and interview on 2/24/2025 at 10:40 a.m. inside Resident 42's room, observed Resident 42's lading mat on the right side of the bed with the overbed table placed on top. During a concurrent observation and interview on 2/24/2025 at 11 a.m. inside Resident 42's room with Treatment Nurse (TN) 2, TN 2 stated Resident 42's overbed table was placed on top of the right landing mat. TN 2 stated that the overbed table can be unstable if placed on top of the floor mat and possibly fall on the residents. TN 2 stated the residents can lose balance and hit the overbed table when getting out of bed	F 689		

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F 689	Continued From page 91	F 689		

unassisted. TN 2 stated the overbed table should have not been placed on top of Resident 42's floor mat as it placed the resident at risk for getting injured when Resident 42 lose balance while trying to get out of bed unassisted.

During a concurrent interview and record review on 2/28/2025 at 1:00 p.m., reviewed a photograph of Resident 42's floor mat dated 2/24/2024 at 10:40 a.m. with the DON, the DON stated Resident 42's overbed table was placed on top of the left floor mat. The DON stated there should always be no furniture or equipment on top of residents' floor mats for resident safety. The DON stated Resident 42's overbed should not have been placed on top of the floor mat to prevent injuries when Resident 42 tries to get out of bed unassisted which may lead to hospitalization.

During a review of the facility's recent P&P titled "Fall Management Program," last reviewed on 12/3/2023, the P&P indicated the facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls; and to provide an environment which remains as free from accident hazards as possible.

During a review of the facility's recent P&P titled "Free of Accident Hazards/Supervision/Devices," last reviewed on 12/3/2024, the P&P indicated the facility provides an environment that is free from accident hazards over which the facility has control, and each resident receives adequate supervision and assistive devices for each resident to prevent avoidable accidents. All staff is involved in observing and identifying potential hazards in the environment. The facility makes

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F 689	Continued From page 92 reasonable efforts to identify the hazards and risk factors for each resident. g. During a review of Resident 83's Admission Record, the Admission Record indicated the facility admitted the resident on 12/23/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), speech disturbances, and generalized muscle weakness. During a review of Resident 83's H&P dated 12/29/2024, the H&P indicated Resident 83 had the capacity to make decisions. During a review of Resident 83's MDS, dated 12/30/2024, the MDS indicated Resident 83 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required total assistance with sit to stand activities and transfers; partial/moderate assistance with eating, oral hygiene, and personal hygiene; substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 83's fall risk assessment dated 12/23/2024, 1/21/2025, and 2/33/2025, the fall risk assessments indicated the resident was a high risk for falls. During a review of Resident 83's CP on unwitnessed fall initiated on 1/30/2025 and last revised on 2/21/2025, the CP indicated to monitor/document/report as needed for 72 hours to physician for signs and symptoms of pain bruises, change in mental status, new onset of	F 689		

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F 689	Continued From page 93 confusion, sleepiness, inability to maintain posture, and agitation as one of the interventions. During a review of Resident 83's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/29/2025, the SBAR indicated Resident 83 had a fall incident on 1/29/2025 at 5:58 p.m. During a concurrent interview and record review on 2/27/2025 at 2 p.m., reviewed Resident 83's SBAR dated 1/29/2025 with Licensed Vocational Nurse (LVN) 4. LVN 4 stated after every fall incident, the resident will be monitored for any signs and symptoms of complication such as change in mental status, increased confusion, and/or visible signs of injury. LVN 4 stated there were no licensed nurses' notes on the following: - 1/29/2025 11p.m. to 7 a.m. shift - 1/30/2025 7 a.m. to 3 p.m. shift - 1/30/2025 3 p.m. to 11 p.m. shift - 1/31/2025 7 a.m. to 3 p.m. shift - 2/1/2025 7 a.m. to 3 p.m. shift - 2/1/2025 3 p.m. to 11 p.m. shift LVN 4 stated the licensed nurses should have documented that Resident 83 was monitored every shift per policy and procedure to ensure Resident 83 was safe after a fall incident. During an interview on 2/289/2025 at 1 p.m. with the DON, the DON stated residents are monitored every shift and documented in the electronic health record for 72 hours after a fall incident to ensure residents are safe and free from complications and to prevent further falls. The DON stated the licensed nurses should have monitored Resident 83 every shift for 72 hours to	F 689		

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F 689	Continued From page 94 ensure Resident 83 is safe and there were no signs and symptoms of complication such as increased confusion, change in mental status, pain, increased bruising and notify the physician as needed. During a f review of the facility's recent P&P titled "Fall Management Program," last reviewed on 12/3/2023, the P&P indicated: -After a fall or other similar accident, the resident shall have a physical assessment documented in the nursing notes in accordance with the facility policy on documenting by exception. -The facility shall begin charting for a minimum of 72 hours after the fall or related accident and continue to assess for latent injuries or changes in condition. During a review of the facility's recent P&P titled, "Documentation Policy," last reviewed on 12/3/2024, the P&P indicated 72-hour charting shall be initiated at the following times: -A significant change in physical, mental, or psychosocial status of the resident (progression, regression, new problems) -An extraordinary event occurs such as falls or injury.	F 689	F690 **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 83's catheter drainage bag was adjusted to ensure the drainage tube did not have a kink or a loop to reduce the potential for development of urinary tract infection on 2/26/2025. Resident 53's catheter drainage bag was adjusted to ensure the drainage tube did not have a kink or loop to reduce the potential for development of urinary tract infection on 2/26/2025. The DON audited Resident 83 and Resident 53's changes in condition 2-1-2025 through 2-26-2025 to identify if either resident developed a urinary tract infection. Neither resident experienced a UTI in the month of February. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;**	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690	Residents using indwelling catheters that have kinks or loops in their tubing are potentially affected. The Director of Nursing audited all resident who have an indwelling catheter on 2/26/2025 to identify residents whose drainage tubes are kinked or looped to identify other residents who may be affected by the facility practice.	

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F 690	Continued From page 95 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents with a urinary catheter (also known as an indwelling catheter, a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI - an infection in the bladder/urinary tract) for two (2) out of 2 sampled residents (Residents 83 and 53) reviewed for urinary catheter or UTI by failing to ensure Residents 83 ' s and 53 ' s urinary catheter tubing did not have a loop while	F 690	No other residents catheter drainage tubing was kinked or looped. No other residents were identified affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Nursing/designee will re-educate the license nurses on or before March 21, 2025, re: the facility policy and procedures "Indwelling Urinary Cathers," with emphasis on ensuring proper placement of the urinary drainage tubing to prevent kinks or loops to decrease the potential for urine backflow and the development of urinary tract infection. The IDT will review physician orders received since the prior business day, each day during the daily clinical meeting held five times weekly, to identify residents admitted with urinary drainage catheters to ensure interventions to ensure tubing is not kinked or looped to reduce the potential for urinary tract infections is present on the care plan. The IDT will review the care plans of all residents with indwelling urinary catheters to ensure all residents receive the necessary care and services to reduce the potential for recurrent urinary tract infections, including proper placement of the urinary drainage tubing on or before 3-13-2025.	

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F 690	Continued From page 96 hanging on the side the bed. This deficient practice had the potential for the resident ' s urine not to flow freely which may lead to development of UTI. Findings: a. During a review of Resident 83 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 12/23/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), neurogenic bladder (a condition in which a person lacks bladder control due to a brain, spinal cord, or nerve condition), and generalized muscle weakness. During a review of Resident 83 ' s History and Physical (H&P), dated 12/29/2024, the H&P indicated Resident 83 had the capacity to make decisions. During a review of Resident 83 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 83 had intact cognition (mental action or process of acquiring knowledge and understanding) and required total assistance with sit to stand activities and transfers; partial/moderate assistance with eating, oral hygiene, and personal hygiene; substantial/maximal assistance from staff with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 83 had an indwelling catheter. During a review of Resident 83 ' s Order	F 690	The Director of Staff Development/designee will continue to provide indwelling urinary catheter care to nursing employees upon hire, annually, and as needed as part of the facility training and education program. The Director of Staff Development orients newly hired staff on the facility policy and procedure indwelling urinary catheter. The DSD will provide skill competency verification to the certified nursing assistants at the time of hire for placement of the urinary catheter drainage tubing to ensure CNAs have the necessary skills to reduce the potential for UTI's by ensuring the urinary drainage tubing is not kinked or looped. Employees identified with variance to standard of practice; and this plan of correction, will be re-educated with skill evaluation, at the time of identification. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Infection Prevention Nurse will monitor resident's with indwelling catheters at the time of admission or when a new catheter is placed to ensure person-centered interventions to reduce the risk for recurrent urinary tract infections are present on the care plan and the nursing staff places the urinary drainage tubing properly to ensure kinks or loops are not present in the tubing.	

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F 690	Continued From page 97 Summary Report, dated 12/23/2024, the Order Summary Report indicated the following physician ' s orders: Indwelling catheter: change urinary catheter every month and as needed if with blockage/ leakage/ removal/ dislodgement every day shift every 30 days and as needed. Indwelling catheter: Indwelling catheter French (FR - a measurement system used to describe the outer diameter of cylindrical objects) 16 per 10 milliliters (ml - a unit of measurement) to drainage bag due to diagnosis of neurogenic bladder. During an observation, on 2/24/2025, at 9:49 a.m., inside Resident 83 ' s room, Resident 83 laid in bed asleep with a urinary catheter drainage bag hanging on the side of the bed. Resident 83 ' s urinary catheter tubing had a loop. During a concurrent observation and interview, on 2/24/2025, at 9:56 a.m., inside Resident 83 ' s room with Licensed Vocational Nurse (LVN) 4, LVN 4 confirmed and stated Resident 83 ' s urinary catheter tubing had a loop, and the loop had urine inside. LVN 4 stated the urinary catheter tubing should not have a loop as the urine will not flow freely or can back up into the bladder and cause UTI. LVN 4 stated Resident 83 ' s urinary catheter tubing should have no loops as it placed Resident 83 at risk for acquiring a UTI when the urine in the tubing cannot flow freely and possibly back up into the bladder. During an interview, on 2/28/2025, at 1:00 p.m., with the Director of Nursing (DON), the DON stated urinary catheter tubing should be positioned properly on the side of the bed to prevent loops or kinks as the urine will not flow	F 690	The charge nurse will monitor residents with indwelling urinary catheters to ensure drainage is properly placed. to reduce the risk of urinary tract infections to the extent possible. The Infection Prevention Nurse/designee will report trends identified in kinked or looped urinary drainage tubing to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025	

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F 690	Continued From page 98	F 690		

freely and go back up into the bladder. The DON stated the staff should check every time they go to the resident ' s room if the urinary catheter tubing had a loop or kink. The DON stated Resident 83 ' s urinary catheter drainage bag should have been placed properly on the side of the bed to prevent kinks or loops as the urine will not flow freely and back up into the bladder which may lead to UTI.

During a review of the facility ' s policy and procedure (P&P) titled, "Indwelling Catheter Use," last reviewed on 12/3/2024, the P&P indicated the facility monitors residents with catheters for changes in skin integrity, skin irritation or breakdown, and signs and symptoms of urinary tract infection.

During a review of the facility provided clinical guideline titled, "Guideline for Prevention of Catheter Associated Urinary Tract Infections," dated 3/25/2024, the clinical guideline indicated to maintain an unobstructed urine flow and to keep the catheter and collecting tube free from kinking as a few of the proper techniques for urinary catheter maintenance.

b. During a review of Resident 53 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/25/2019 and readmitted the resident on 1/19/2024 with diagnoses including cerebral infarction (also known as stroke, loss of blood flow to a part of the brain), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and neurogenic bladder (a condition in which a person lacks bladder control due to a brain, spinal cord, or nerve

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F 690	Continued From page 99 condition). During a review of Resident 53 ' s H&P, dated 1/21/2025, the H&P indicated Resident 53 did not have the capacity to understand and make decisions. During a review of Resident 53 ' s MDS, dated 12/27/2024, the MDS indicated Resident 53 had severely impaired cognition and required total assistance from staff with all ADLs. The MDS indicated Resident 53 had an indwelling catheter. During a review of Resident 53 ' s Order Summary Report, the Order Summary Report indicated the following physician ' s orders: On 1/22/2025, Indwelling catheter: Indwelling catheter Fr 16/10 ml to drainage bag due to diagnosis of neurogenic bladder. On 1/24/2025, Indwelling catheter: change urinary catheter every month and as needed if with blockage/ leakage/ removal/ dislodgement) every day shift every 30 days and as needed. On 1/24/2025, Indwelling catheter: Flush urinary catheter with 50 ml normal saline (NS - a saltwater solution) every day for sedimentation (solid particles settling down to the bottom of a liquid) and cloudiness as needed. During a review of Resident 53 ' s CP on indwelling catheter, initiated on 1/24/2024 and last reviewed on 1/23/2025, the CP indicated interventions including to check tubing for kinks each shift and anchor safely to minimize Resident 53 ' s risk of urinary infection. During an observation, on 2/26/2025, at 8:30 a.m., inside Resident 53 ' s room, Resident 53 laid in bed asleep with a urinary catheter drainage	F 690		

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F 690	Continued From page 100	F 690		

bag hanging on the side of the bed. The urinary catheter tubing had a loop.

During a concurrent observation and interview, on 2/26/2025, at 8:35 a.m., inside Resident 53 ' s room, with LVN 7, LVN 7 confirmed and stated Resident 53 ' s urinary catheter tubing had a loop, and the loop had urine inside. LVN 7 stated the urinary catheter tubing should not have a loop as the urine will not flow freely, can back up into the bladder and cause UTI. LVN 7 stated Resident 53 ' s urinary catheter tubing should have no loop as it placed Resident 53 at risk for acquiring UTI.

During an interview on 2/28/2025, at 1 p.m., with the DON, the DON stated urinary catheter tubing should be positioned properly on the side of the bed to prevent loop or kink as the urine will not flow freely and go back up into the bladder. The DON stated the staff should check every time they go to the resident ' s room if the urinary catheter tubing had a loop or kink. The DON stated Resident 53 ' s urinary catheter drainage bag should have been placed properly on the side of the bed to prevent kink or loop as the urine will not flow freely and back up into the bladder which may lead to UTI.

During a review of the facility ' s P&P titled, "Indwelling Catheter Use," last reviewed on 12/3/2024, the P&P indicated the facility monitors residents with catheters for changes in skin integrity, skin irritation or breakdown, and signs and symptoms of urinary tract infection.

During a review of the facility provided clinical guideline titled, "Guideline for Prevention of Catheter Associated Urinary Tract Infections," dated 3/25/2024, the clinical guideline indicated to

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F 690	Continued From page 101 maintain an unobstructed urine flow and to keep the catheter and collecting tube free from kinking as a few of the proper techniques for urinary catheter maintenance.	F 690	**F695 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 29's physician assessed the use of the CPAP machine and provided orders for its use and monitoring. The licensed nurse transcribed the physician order for the use and monitoring of Resident 29's CPAP machine on 2/26/2025. The Director of Maintenance evaluated the CPAP machine's safety and integrity on 2/26/2025. The licensed staff are monitoring Resident 29's use of CPAP machine daily and documenting the monitoring in the treatment administration record. The CPAP machine is cleaned routinely per manufacturer's guidelines by the Licensed Vocational Nurses. The IDT developed and initiated a care plan for the use of Resident 29's CPAP including interventions for assessment and monitoring of Resident 29's respiratory status and care of the CPAP machine on 2/26/2025.	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents were consistent with professional standards of practice for one of three sampled residents (Resident 29) reviewed for respiratory care by failing to ensure Resident 29 ' s home continuous positive airway pressure (CPAP - a machine that uses mild air pressure to keep breathing airways open while you sleep) machine had: A physician ' s order to use in the facility including parameters of oxygen administration and indication for use. An assessment of the home CPAP machine ' s integrity, monitoring of the resident ' s respiratory condition, including response to therapy. A care plan that includes interventions for CPAP	F 695		

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 102 therapy. Been cleaned daily per manufacturer ' s guidelines on cleaning the mask and the CPAP tubing. These deficient practices had the potential for residents to receive inappropriate oxygen therapy and develop complications such as respiratory infections due to the CPAP mask and tubing not being cleaned per manufacturer ' s guidelines. Findings: During a review of Resident 29 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2025, with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), asthma (a chronic [long-term] condition that affects the airways in the lungs), and obstructive sleep apnea (the most common sleep-related breathing disorder). During a review of Resident 29 ' s History and Physical (H&P), dated 1/23/2025, the H&P indicated the resident had obstructive sleep apnea and was on CPAP at bedtime. The H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 29 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/29/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (someone's mental abilities, like thinking,	F 695	**B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents using home CPAP machines are potentially affected by the facility practice. The Assistant Director of Nursing audited all residents who use CPAP machines. A total of 3 residents use CPAP machines. 0 of 3 residents CPAP machines were brought from home. No other residents identified affected by the facility practice. The IDT audited care plans of residents who use a CPAP machine for respiratory conditions to ensure interventions including an assessment, physician order, monitoring and cleaning were present on 2/26/2025. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Nursing/designee will re-educate the nursing staff on or before 3/21/2025, re: the facility policy and procedures, Care Planning," with emphasis on residents with CPAP therapy must have person centered interventions based on the assessment including evaluation of the safety and integrity of a CPAP	

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F 695	Continued From page 103 remembering, understanding, and reasoning, are fully functional and working normally, with no significant impairments or decline in cognitive skills). During a review of Resident 29 ' s Order Summary Report, the Order Summary Report did not indicate an order for home CPAP machine use in the facility. During a concurrent observation and interview, on 2/24/2025, at 9:56 a.m., with Resident 29, inside Resident 29 ' s room, Resident 29 wore a mask connected to a CPAP machine at the bedside. The CPAP machine was on. Resident 29 stated he came in the facility with the home CPAP machine, and nobody had checked it and the CPAP mask. Resident 29 stated the mask and the tubing were not changed for a few weeks. During a concurrent observation, interview, and record review, on 2/26/2025, at 8:29 a.m., with Registered Nurse (RN) 1, inside Resident 29 ' s room, Resident 29 wore a mask connected to his home CPAP machine. Resident 29 ' s Order Summary Report, Assessments, and Care Plans were reviewed with RN 1. RN 1 confirmed and stated there was no physician ' s order to use the home CPAP machine in the facility, nobody in the facility has assessed the integrity of the resident ' s home CPAP machine, there is no assessment on the resident ' s response to the therapy, and the resident had no care plan on home CPAP machine use. RN 1 stated the CPAP mask, and tubing should be cleaned per manufacturer ' s guideline to prevent respiratory infection to the resident. RN 1 stated the licensed nurses should have obtained a physician ' s order for the home CPAP machine to be used in the facility,	F 695	machine, when brought from home, No Smoking sign at the resident's door, tubing and mask materials, routine evaluation of respiratory condition trough pulse oximeter and routine cleaning per manufacturers guidelines for the CPAP machine. The Interdisciplinary Team will evaluate newly admitted residents for to identify residents with CPAP therapy to ensure the completion of an assessment, physician order and comprehensive person centered care plan with interventions for CPAP therapy, routine cleaning of the mask and replacement of the tubing, and cleaning of the CPAP machine. Charge nurses will complete routine pulse oximetry each shift of residents with CPAP machines. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Infection Prevention Nurse/designee will monitor residents who use CPAP therapy to ensure cleanliness of the mask, tubing and machine per manufacturer's' guidelines to reduce the risk of residents developing respiratory infection. The Charge Nurse will monitor the residents' respiratory health, assess the resident's pulse oximetry and document in the medication administration record each shift. Concerns identified will be corrected at the time of observation and reported to the Director of Nursing.	

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F 695	Continued From page 104 assessed the CPAP machine for its integrity and monitored the resident ' s response to the therapy, and developed and implemented a care plan on home CPAP machine use in the facility to ensure its safe use. RN 1 stated the care plan helps standardize the care being provided to the resident and serves as a communication to all healthcare disciplines. During a concurrent interview and record review, on 2/26/2025, at 8:41 a.m., with Respiratory Therapist (RT) 1, RT 1 stated it was the responsibility of licensed nurses to obtain an order for the home CPAP machine for Resident 29. RT 1 stated there should be an assessment of the home CPAP machine to ensure it is working properly and a care plan should have been developed and implemented to include the settings and what respiratory assessments needed to be done to the resident while on the home CPAP machine. During an interview, on 2/27/2025, at 11:57 a.m., with the Infection Preventionist (IP), the IP stated she found Resident 29 ' s home CPAP machine ' s manufacturer ' s user manual and the user manual indicated to gently wash the tubing and mask adaptor in a solution of warm water and a liquid dish soap, rinse thoroughly, air dry, inspect the tubing and mask adaptor for damage or wear daily, and discard and replace if necessary. The IP stated the failure of the staff to clean the tubing and mask adapter had the potential for residents to develop respiratory infections. During an interview, on 2/28/2025, at 9:10 a.m., with the Director of Nursing (DON), the DON stated they allow the residents to use their own CPAP machine in the facility and if the resident	F 695	The Director of Nursing will monitor the licensed nurses' performance through observation and IPN reports; and provide re-education or progressive disciplinary action as indicated. The DON/designee will report trends identified in CPAP therapy to the Quality Assurance committee during the quarterly QA&A meeting for the purpose of process improvement changes to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025	

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F 695	Continued From page 105 does not have one, they provide the residents. The DON stated before using Resident 29 ' s home CPAP machine, the facility should have a physician's order for the machine setting, perform face mask fitting, have an indication, and a care plan on its use. The DON stated it was important to have all the mentioned requirements because without all the requirements, the facility cannot monitor for the effectiveness of the treatment and will not be able to determine the reason for its use. The DON also stated the failure of the staff to clean Resident 29 ' s CPAP mask and tubing daily with warm water and dish washing solution per manufacturer's guideline had the potential for residents to develop infection. The DON stated it was the responsibility of the licensed nurses and respiratory therapist to ensure there was a physician's order, a face mask fitting, indication, a care plan, and a pulse oximeter (an electronic device that measures the saturation of oxygen carried in your red blood cells) for use of the resident on CPAP. During a review of the facility's recent policy and procedure (P&P) titled, "Bilevel Positive Airway Pressure (BIPAP - a type of device that helps with breathing [ventilator]) and CPAP Therapy," last reviewed on 12/3/2024, the P&P indicated to provide clinical practice guidelines for the care and treatment of the resident who uses a positive airway pressure machine for treatment of sleep apnea. Both CPAP and BiPAP machines allow residents to breathe easily and regularly throughout the night. Review the physician's order to determine the oxygen concentration and flow, and the Positive end-expiratory pressure (PEEP - a setting on a breathing machine that keeps a little bit of pressure in the lungs even after you breathe out, helping to prevent the tiny air sacs	F 695		

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F 695	Continued From page 106 from collapsing and ensuring proper oxygen exchange, especially for people who can't breathe on their own fully), Inspiratory Positive Airway Pressure (IPAP - pressure delivered by the ventilator while the patient is inhaling), and Expiratory Positive Airway Pressure (EPAP - pressure delivered by the ventilator while the patient is exhaling) for the machine. Review and follow manufacturer's instructions for CPAP machine setup and oxygen delivery. EQUIPMENT 1. NO SMOKING sign for the resident's room. 3. Disposable circuit tubing with mask and head strap. 7. Pulse oximeter. During a review of the facility's recent P&P titled, "Infection Prevention and Control Program," last reviewed on 12/3/2024, the P&P indicated to ensure the facility establishes and maintains an infection control program designated to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. During a review of the facility's recent P&P titled, "Develop-Implement Comprehensive Care Plans," last reviewed on 12/3/2024, the P&P indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. During a review of the facility-provided User Manual titled, "CPAP 1," undated, the User Manual indicated under Cleaning the Tubing,	F 695		

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F 695	Continued From page 107 hand wash the tubing and the mask adaptor (if included) before first use and daily. For daily cleaning, disconnect the tubing from the device and the mask, and if included, disconnect the mask adaptor from the tubing. For the flexible tubing, gently wash the tubing and mask adaptor in a solution of warm water and a liquid dish soap. Rinse thoroughly. Air dry. Inspect the tubing and mask adaptor for damage or wear. Discard and replace if necessary.	F 695	**F697 Pain Management** **CFR(s): 483.25(k)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The licensed nurse completed a pain assessment of Resident 65 to ensure current pain management program is effective on 2/24/2025.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice related to pain management for one (1) of 1 sampled resident (Resident 65) reviewed for pain management when Certified Nursing Assistant (CNA) 1 failed to recognize and address Resident 65 ' s verbalization of pain while providing activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily) care. This deficient practice had the potential for Resident 65 to be subjected to unnecessary pain affecting the resident ' s quality of life and comfort.	F 697	CNA 1 received 1:1 re-education on the facility procedure to report resident complaints of pain to the charge nurse for further evaluation on 2/24/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents cared fr by certified nurse assistant 1 are potentially affected. The Charge Nurse interviewed residents cared for by CNA 1 on 2/24/2025 and completed a pain assessment in the medication administration record to identify residents who had unreported complaints of pain. No other residents had complaints of pain that were not conveyed to the charge nurse. No other residents were affected by the facility practice.	

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F 697	Continued From page 108 Cross-reference F677 and F880. Findings: During a review of Resident 65 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/8/2021 and readmitted in the facility on 1/10/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication), and generalized muscle weakness. During a review of Resident 65 ' s History and Physical (H&P), dated 1/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 65 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required partial/moderate assistance with toileting hygiene, bathing, and lower body dressing; substantial/maximal assistance from staff with all other ADLs. During a review of Resident 65 ' s Order Summary Report, dated 1/13/2025, the Order Summary Report indicated a physician ' s order for: Norco Tablet 5-325 MG (hydrocodone-acetaminophen - a type of strong combination of pain medication that contains a narcotic to	F 697	**C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development/designee will re-educate the certified nursing assistants starting on 3/18/25 regarding the facility policy and procedures "Pain Assessment and Management" requirements for CNAs to report residents complaints of pain when a resident has: 1. Non-verbal pain indicators, as patient applicable, 2. Verbal report of pain on a 1-10 pain scale where 10 is the most severe level of pain. The DSD, as part of the facility's new employee orientation, will educate certified nursing assistants on the facility policy and procedure for reporting residents' complaints of pain or observations of non-verbal indicators of pain to the charge nurse for management of resident pain. The charge nurse will evaluate residents' pain level each shift and provide pain medication as indicated. Each resident will be evaluated for pain at the time of admission, quarterly, annually and with an exacerbation as well as each shift to ensure resident's receive adequate pain manage to reduce the potential for residents to refuse care related to discomfort.	

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F 697	Continued From page 109 manage moderate to severe pain) give 1 tablet by mouth every six (6) hours as needed for moderate scale of four (4) to 6 out of 10 to severe pain seven (7) to 10 out of 10 not to exceed three (3) grams (gm - a unit of measurement) of total acetaminophen per day. Hold for sedation and or respiratory rate (RR) of less than12. During a review of Resident 65 ' s care plan (CP) on risk for pain, initiated on 1/12/2025 and last revised on 1/24/2025, the CP indicated to administer pain medication as ordered, anticipate resident ' s need for pain relief and respond immediately to any complaint of pain, keep resident in comfortable position, monitor or document for probable cause of each pain episode, and remove or limit causes where possible as a few of the interventions to prevent Resident 65 ' s interruption in normal activities due to pain. During a concurrent observation and interview, on 2/24/2025, at 10:27 a.m., inside Resident 65 ' s room, with CNA 1, CNA 1 provided ADL care to Resident 65. Resident 65 verbalized pain with slight pulling of the left leg while CNA 1 placed a sock on Resident 65 ' s left foot. Resident 65 pointed to her left foot and stated she had a lot of pain on the toes. CNA 1 proceeded to place the sock again on the left foot and Resident 65 complained of pain again by screaming and pulling her left leg and telling CNA 1 not to touch her leg. CNA 1 stated she was trying to put the socks on Resident 65, complete her task, and notify the Charge Nurse (CN) after. CNA 1 stated when residents complain of pain or refusing to continue with ADL care, the staff should notify the CN. CNA 1 stated she should have stopped and not try to put the socks on again on Resident 65	F 697	**D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Staff Development is responsible for monitoring certified ursing assistants' skill validation during new hire orientation, annually and as needed when a variance to standard is identified in reporting a resident's verbal complaints of pain. Competency related concerns identified by the DSD will be reported to the Director of Nursing for further review and instruction as indicated. The Director of Staff Development/designee will report significant trends identified in the DSD pain management skill reports to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction; or for the purpose of terminating this plan of correction when substantial compliance has been achieved. Allegation Of Compliance Date: 3/25/2025.	

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F 697	Continued From page 110	F 697		

and notify the CN to give the resident pain medication. CNA 1 stated if the pain was not addressed Resident 65 will continue to refuse ADL care.

During an interview, on 2/24/2025, at 10:35 a.m., with Licensed Vocational Nurse (LVN) 9, LVN 9 stated CNAs are supposed to stop providing care to residents as soon as the residents verbalized pain accompanied with refusal to be touched during care and notify the CN to address pain and administer pain medication timely. LVN 9 stated CNA 1 should have stopped and not attempt to place Resident 65 ' s sock on the left foot the second time and notified the CN to administer pain medication timely to prevent continued refusal of care and lead to decline in functioning.

During an interview, on 2/28/2025, at 1:00 p.m., with the Director of Nursing (DON), the DON stated when a resident verbalizes pain during ADL care, the CNA should stop providing care, ask the resident the location of the pain, how much pain the resident is having, and notify the CN to address resident ' s pain. The DON stated CNA 1 should have not attempted to place Resident 65 ' s sock on the left foot again when the resident initially complained of pain. The DON stated CNA 1 should have stopped providing care to Resident 65 and notified the CN to address the pain timely. The DON stated not recognizing and addressing Resident 65 ' s pain timely placed the resident at risk for continuation to refuse care and/or treatment participation in ADLs or therapy which may lead to decline in function.

During a review of the facility ' s policy and procedure (P&P) titled, "Pain Management," last reviewed on 12/3/2024, the P&P indicated the

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F 697	Continued From page 111 following: Recognizing Pain: 1. Observe the resident (during rest and movement) for physiologic and behavioral (nonverbal) signs of pain. 2. Possible Behavioral Signs of Pain: a. Verbal expressions such as groaning, crying, screaming; b. Facial expressions such as grimacing, frowning, clenching of the jaw, etc.; c. Changes in gait, skin color and vital signs; d. Behavior such as resisting care, irritability, depression, decreased participation in usual activities; e. Limitations in his or her level of activity due to the presence of pain; 3. Ask the resident if he/she is experiencing pain. Be aware that the resident may avoid the term "pain" and use other descriptors such as throbbing, aching, hurting, cramping, numbness or tingling.	F 697	**F755 Pharmacy Srvcs Procedures Pharmacist/Records CFR(s): 483.45 (a)(b) (1)-(3)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1. LVN 4 signed Resident 87 Clonazepam ODT 0.5mg. at 1:40pm, reconciling the narcotic log and remaining Clonazepam for Resident 87 on 2/25/2025. LVN 3 signed Resident 93s Lorazepam 1mg 1:07pm, reconciling the narcotic log and remaining Lorazepam for Resident 93 on 2/25/2025. LVN 3 and LVN 4 were re-educated by the Director of Nursing/designee on 2/25/2025 on the facility policy and procedure Administering Medications with emphasis on the standard of practice pour, pass, chart to ensure medications including controlled substances are signed reconciled on the narcotic log and medication administration record when the medication is administered. 2. LVN 6 administered Resident 347's Alprazolam on 2/25/2025. LVN 6 and LVN 7 were re-educated by the Director of Nursing/designee on 2/25/2025 on the facility policy and procedure assessing and administering as needed medications when residents	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 755	Continued From page 112 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) by failing to: 1. Accurately account for two doses of controlled medications (medications with a high potential for abuse) affecting Residents 87 and 93 in two of four inspected medication carts on Station 2 Cart 1 and Station 3 Cart 1. This deficient practice increased the risk of diversion (any use other than that intended by the prescriber) of controlled mediations and the risk that Residents 87 and 93 could have received too much or too little medication due to a lack of documentation possibly resulting in serious health complications requiring hospitalization.	F 755	request these medications. 3. Resident 197 discharged on 3/4/25. Resident's MD declined to have thyroid hormone level checked after the discovery of missed doses. MD was notified about the missed doses on 2/28/25 with no new orders. Licensed Nurses are administering Resident 197's levothyroxine in accordance with the physician order. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents with controlled substances are potentially and residents not receiving medications as ordered by the physician are potentially affected. The Assistant Director of Nursing/designee completed a controlled substance count of controlled medications at the time of the survey on 2/25/2025 to identify potentially affected residents. All controlled substances were compliant during reconciliation and the deficient practice was isolated to LVN 3 and LVN 4. All residents are potentially affected by not receiving their as needed medications when requested.	

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F 755	Continued From page 113 2. Administer alprazolam (a medication to treat anxiety [a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear]) for one of three sampled residents (Resident 347) reviewed during the Behavioral- Emotional care area, when Resident 347 requested medication on 2/24/2025 at 6 a.m. This deficient practice resulted in Resident 347 reporting continued feelings of anxiousness on 2/24/2025 at 10 a.m. and had the potential to result in increased anxiety and risk for a decline in the resident's psychosocial wellbeing. 3. Administer Resident 197's three doses of levothyroxine (used to treat hypothyroidism [a condition where the thyroid gland does not produce enough thyroid hormone]) as ordered when a discrepancy of three doses of levothyroxine were observed in the bubble pack. This deficient practice had the potential to result in Resident 197's fluctuations in thyroid hormone levels, leading to symptoms of hypothyroidism such as fatigue, cold intolerance, and constipation. Findings: 1. a. During a review of Resident 87's Admission Record (a document containing a resident's diagnostic and demographic information), dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 10/28/22 and most recently readmitted on 12/13/22 with diagnoses including seizures (sudden, uncontrolled burst of electrical activity in the brain that can cause	F 755	**C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** License Nurse 7 was re-educated by the Director of Nursing/designee on 2/25/2025, on the facility policy and procedure, "Medication Administration" with emphasis on administering as needed medications when residents request such medications. LVN 3 and LVN 4 were re-educated by the Director of Nursing/designee on 2/25/2025 on the facility policy and procedure Administering Medications with emphasis on the standard of practice pour, pass, chart to ensure medications including controlled substances are signed reconciled on the narcotic log and medication administration record when the medication is administered. The DSD, as part of the facility's employee orientation will educate licensed nurses re: facility policy and procedure for medication administration including evaluation of the nurse's competency to pass and reconcile controlled medications, administering medications per physician order and prompt administration of as needed medications when residents request the need for such medications. The Director of Staff Development completed a medication pass observation skill competency of LVN 3, 4, 6 & 7 on 3/21/2025.	

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F 755	Continued From page 114 changes in movement, behavior, feelings, or awareness). During a review of Resident 87's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 2/18/2025, the H&P indicated her cognition was poor but did not indicate whether she had the capacity to understand and make decisions or not. During a review of Resident 87's Physician Order Summary (a monthly summary of all active physician orders), dated 2/27/2025, the Physician Order Summary indicated Resident 87 was prescribed clonazepam ODT (a controlled medication used to treat seizures) 0.5 milligrams (mg - a unit of measure for mass) by mouth three times daily for "seizure management" on 2/22/2025. During an observation of Station 2 Cart 1 on 2/25/2025 at 1:40 p.m. and concurrent interview with Licensed Vocational Nurse (LVN 4), the following discrepancies were found between the Drug Control Receipt Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication) or physical inventory: 1. Resident 87's Drug Control Receipt Record for clonazepam ODT 0.5 mg indicated there were six doses left, however, the physical inventory contained five doses. LVN 4 stated she administered the missing dose of clonazepam to Resident 87 around 10 a.m. that day. LVN 4 stated she understands that she needs to sign out the doses of controlled	F 755	**D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Staff Development is responsible for monitoring licensed and certified nurse assistant staff competency during new hire orientation, annually and as needed when a variance to standard is identified re: the facility's "Medication Administration," policy and procedure. Competency related concerns identified by the DSD will be reported to the Director of Nursing for further review and instruction as indicated. The Consultant Pharmacist will conduct random medication pass observation audits of licensed nurses to ensure medication administration practices are consistent with the standard of practice and facility policy and procedure once per month. Results of the Pharmacist audits will be provided to the Director of Nursing and reported to the QAA Committee at a minimum, quarterly, for the purpose of process improvement. The Director of Nursing/designee will report significant findings identified in the medication administration skill competency audits to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued	

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F 755	Continued From page 115 medication on the Drug Control Receipt Record immediately after the medication is removed from the bubble pack or supply. LVN 4 stated she failed to sign for the missing dose earlier because she was distracted by other tasks and did not remember to do it when she returned. LVN 4 stated it is important to maintain accountability of controlled substances to prevent diversion or accidental overdose to the resident. LVN 4 stated if Resident 87 received clonazepam more often than prescribed, it could cause medical complications possibly leading to hospitalization. 1.b. During a review of Resident 93's Admission Record, dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 5/23/23 and most recently readmitted on 2/5/25 with diagnoses including seizures. During review of Resident 93's H&P dated 10/26/2024, the H&P indicated she had the capacity to understand and make decisions. During a review of Resident 93's Physician Order Summary, dated 2/27/2025, the Order Summary Report indicated she was prescribed lorazepam (a controlled medications used to treat seizures) 1.5 mg (as one and one-half 1 mg tablets) via gastrostomy tube (g-tube - a tube surgically implanted into the stomach for administration of medications and nutrition) once daily on Tuesday, Thursday, and Saturday for "anxiety manifested by repetitive anxious complaints" on 2/5/2025. During an observation of Station 3 Cart 1 on 2/25/2025 at 1:59 p.m. and a concurrent interview with LVN 3, the following discrepancies were found between the Drug Control Receipt Record and the medication card or physical inventory:	F 755	compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025	

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F 755	Continued From page 116 1. Resident 93's Drug Control Receipt Record for lorazepam 1 mg tablets indicated there were 12 doses left, however, the medication card contained 11 doses. LVN 3 stated she gave the missing medication to Resident 93 at approximately 1:07 p.m. that day. LVN 3 stated she was supposed to sign the dose out on the Drug Control Receipt Record immediately before it was administered to the resident. LVN 3 stated she failed to sign it because she forgot. LVN 3 stated signing the controlled drug record ensures the count is correct to prevent any missing medications and possibly prevent the resident from receiving it more often than necessary. LVN 3 stated if Resident 93 received lorazepam more often than prescribed, it could cause additional drowsiness or other adverse effects which could negatively impact her health or well-being. During a review of the facility's policy and procedures (P&P) titled "Controlled Substances," revised April 2018, the P&P indicated "Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following on the accountability record ... date and time of administration ... initials of nurse administering the dose, and completed after the medication is actually administered ..." 2. During a review of Resident 347's Admission Record, the Admission Record indicated the facility admitted the resident on 2/21/2025 with diagnoses that included generalized anxiety, depressive disorder (depression - persistent feelings of sadness and loss of interest that can interfere with daily living), and dependence on renal dialysis (a treatment to cleanse the blood of	F 755		

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F 755	Continued From page 117	F 755		

wastes and extra fluids artificially through a machine when the kidney(s) have failed).

During a review of Resident 347's H&P, dated 2/28/2025, the H&P indicated the resident had the capacity to understand and make decisions.

During a review of Resident 347's Order Summary Report, dated 2/26/2025, the Order Summary Report indicated an order to administer alprazolam oral tablet 0.5 milligrams (mg - a unit of measurement), one tablet by mouth every six hours, as needed for anxiety manifested by physical movements of restlessness for 14 days.

During a review of Resident 347's Care Plan (CP) titled, "(Resident 347) is on alprazolam...." initiated on 2/22/2025, the CP indicated a goal that the anti-anxiety medication would be effective with an intervention to give medication as ordered by the physician.

During a concurrent observation, interview, and record review on 2/24/2025 at 10 a.m. with LVN 6, LVN 6 reviewed Resident 347's Medication Administration Record (MAR - - a record of all medications taken by a resident on a day-to-day basis) and Progress Notes. Resident 347 was observed lying in bed and stated she was newly admitted to the facility. Resident 347 stated she felt anxious and had requested medication at 6 a.m. and never saw the nurse again. Resident 347 was observed to activate the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need). LVN 6 entered Resident 347's room and Resident 347 stated "Oh, there you are, I haven't seen you all morning." Resident 347 stated she felt anxious

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F 755	Continued From page 118 and depressed and did not receive the medication she requested at 6 a.m. LVN 6 stated she arrived early to work while the night shift nurse was still providing care to Resident 347. LVN 6 stated Resident 347 had requested alprazolam at 6 a.m. and she notified Licensed Vocational Nurse 7 (LVN 7) to give the medication. LVN 6 reviewed the MAR and noted alprazolam was not administered on 2/24/2025. LVN 6 stated alprazolam was a medication that was ordered to be given as needed and the resident should have received the medication as soon as possible upon the resident's request, but she did not. LVN 6 stated she would give the resident the alprazolam. During an interview on 2/25/2025 at 6:06 a.m. with LVN 7, LVN 7 stated the usual process for the administration, of as needed medication, is the nurse will be notified that the resident is requesting the medication. The nurse will assess the resident as soon as possible, and the medication will be administered at that time. LVN 7 stated on 2/24/2025 she did not assess Resident 347 for the need for alprazolam and she did not administer alprazolam to the resident. LVN 7 stated on 2/24/2025 she thought LVN 6 was going to give Resident 347 the alprazolam, so she did not administer it. LVN 7 stated when Resident 347 requested alprazolam at 6 a.m. and the medication was not administered until after 10 a.m., it was considered a delay in the delivery of the medication which could have resulted in Resident 347 having an anxiety attack (episodes of intense anxiety that lead to severe cognitive, emotional, and physical symptoms) with feelings of stress, fear, and impending doom. During a concurrent interview and record review	F 755		

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F 755	Continued From page 119 on 2/28/2025, at 11 a.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding medication administration. The DON stated when a resident requests an as needed medication, the nurse should assess the resident and provide interventions at that time. The DON stated if the resident required medication, then the nurse should administer the medication. The DON stated Resident 347 should have been assessed and administered alprazolam when the resident requested the medication, but she was not. The DON stated waiting more than three hours to administer alprazolam to Resident 347 was too long and could have resulted in increased anxiety in the resident affecting their ability to participate in their normal activities of daily living and negatively impact their psychosocial wellbeing. The DON stated the facility policy was not followed when Resident 347 was not delivered the alprazolam when it was requested. During a review of the facility P&P titled, "Administering Medications," last reviewed on 12/3/2025, the P&P indicated the purpose of the policy was to provide employees with guidelines for the safe and timely administration of medications per physician orders. Medications must be administered in accordance with the orders. During a review of the facility's P&P titled, "Medication Errors," last reviewed on 12/3/2025, the P&P indicated the facility ensures that its residents are free of any significant medication errors. A medication error is the observed or identified preparation or administration of medications or biologicals which is not in accordance with accepted professional standards	F 755		

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F 755	Continued From page 120	F 755		

and principles which apply to professionals providing services. A delivery error is a drug product not received by the resident at the expected time.
3. During a review of Resident 197's Admission Record, the Admission Record indicated the resident was admitted on 2/17/2025 with diagnoses including presence of left artificial hip joint, hypertensive heart disease (high blood pressure), and hypothyroidism.

During a review of Resident 197's H&P, dated 2/18/2025, the H & P indicated the resident had the capacity to understand and make decisions.

During a review of Resident 197's physician order, dated 2/17/2025, the physician's order indicated levothyroxine sodium oral tablet 75 micrograms (mcg-a unit of measurement) give one tablet by mouth one time a day for hypothyroidism.

During a review of Resident 197's Care Plan Report, dated 2/18/2025, the Care Plan Report indicated the resident has hypothyroidism and required daily thyroid replacement. The Care Plan Report included interventions to administer thyroid replacement therapy as ordered and to monitor or document for side effects and effectiveness done by the licensed nurses.

During an interview on 2/24/2025 at 10:18 a.m. with Resident 197, Resident 197 stated she has been here since 2/17/2025 and she has only received her thyroid medication only two to three times this week. Resident 197 stated she has not received her thyroid medication this morning.

During a concurrent observation and interview on

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F 755	Continued From page 121	F 755		

2/27/2025 at 6:23 a.m. with LVN 1, while in Nursing Station 1, Resident 197's levothyroxine bubble pack was inside the medication cart. LVN 1 stated the levothyroxine 75 mcg tablet bubble pack was filled on 2/17/2025 with a total of five (5) doses/tablets which were administered. LVN 1 stated he has not administered today's dose yet because Resident 197 preferred to receive it at 7 a.m.

During a concurrent interview and record review on 2/28/2025 at 7:17 a.m. with LVN 1, Resident 197's Medication Administration Record (MAR), dated 2/1/2025 - 2/28/2025 was reviewed. The MAR indicated, a total of 10 doses of levothyroxine were administered from 2/18/2025 to 2/28/2025. LVN 1 stated, there was a total of 15 doses in the bubble pack and eight tablets were still in the bubble pack. LVN 1 stated there were three (3) tablets that were not administered. LVN 1 stated when Resident 197's levothyroxine are not administered the resident could have confusion.

During an interview on 2/28/2025 at 8:47 a.m., with the DON, the DON stated Resident 197's medication should be administered as ordered and is given to treat specific diseases and be monitored. The DON stated when medication is not administered it could affect Resident 197's thyroid functioning and the resident should be monitored for any changes. The DON stated LVN 1 should call the doctor and family/representative informing them of what happened.

During a review of the facility's P&P titled, "Administering Medications," last reviewed on 12/3/2025, the P&P indicated the purpose of the policy was to provide employees with guidelines

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F 755	Continued From page 122 for the safe and timely administration of medications per the physician order. Medications must be administered in accordance with the orders.	F 755	**F756 Drug Regimen Review CFR(s): 483.45(c)(1)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The licensed nurse clarified Resident 101's use of Lorazepam PRN and the consultant pharmacists recommendation from 11/24/2024 on 2/24/2025. Resident 101's use of guaifenesin oral liquid was discontinued on 2/27/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents with consultant pharmacist recommendations that have not been responded to are potentially affected by the facility practice. The Director of Nursing requested a consultant pharmacist report on 2/28/2025 of recommendations that have not been responded to for the dates 11/1/2024 through 2/28/2025 to ensure the residents' physicians were contacted and a response was received. The consultant pharmacist provided a list of 0 residents recommendations requiring responses. All consultant pharmacist recommendations were completed.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 756	Continued From page 123 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Respond to the consultant pharmacist's (a medical professional responsible for a monthly review of all residents' medication regimens) recommendation from 11/30/2024 to limit the duration of PRN (as needed) lorazepam (a medication used to treat mental illness) to 14 days or define a specific length of therapy for one of five residents sampled for unnecessary medications (Resident 101). 2. Respond to the consultant pharmacist's recommendation from 12/31/2024 to define the length of therapy with guaifenesin oral liquid (a medication used to treat cough/congestion) for one of five residents sampled for unnecessary medications (Resident 101). The deficient practice of failing to ensure the facility responded to medication irregularities (potential issues with a resident's medication regimen) identified by the consultant pharmacist during the Medication Regimen Review (MRR - a monthly report from the consultant pharmacist identifying any medication irregularities in a resident's current medication regimen) increased the risk that Resident 101 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug	F 756	**C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Nursing revised the facility system for responding to the consultant pharmacist recommendations and filing the MRR in the resident record when an MRR is completed by the consultant pharmacist. The Director of Nursing receives and reviews the pharmacy recommendations from the pharmacist monthly. A copy of the MRR is maintained by month in the DON office. The Nurse Supervisor will receive a copy of the recommendations for timely completion. When completed, the nurse supervisor will file the MRR in the resident's record and provide a copy to the Director of Nursing for review. The Director of Nursing/designee will re-educate the licensed on or before 3/21/2025 on the facility policy and revised procedure. Drug Regimen Review," emphasizing timely completion and filing in the resident's medical record. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Consultant Pharmacist completes	

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F 756	Continued From page 124 may have) related to their medication therapy possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status. Cross-referenced F757, F758 Findings: During a review of Resident 101's Admission Record (a document containing a resident's diagnostic and demographic information), dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 5/15/2024 with diagnoses including: anxiety disorder (a mental illness characterized by persistent worry or fear strong enough to interfere with daily life). During a review of Resident 101's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 1/3/2025, the H&P indicated she had "worsening functional and cognitive decline" but did not indicate whether she had the capacity to understand and make decisions. During a review of Resident 101's Order Audit Report (a report containing details and a timeline regarding a specific physician order), dated 2/26/2025, the Order Audit Report indicated she was prescribed lorazepam 2 milligrams (mg a unit of measure for mass) per milliliter (ml - a unit of measure for volume) oral concentrate to take 1 ml by mouth every four hours as needed for anxiety between 5/15/2024 and 2/24/2025. During a review of Resident 101's Physician Order Summary (a monthly summary of all active physician orders), dated 2/26/2025, the Physician	F 756	Medication Regimen Reviews monthly and provides a list of recommendations to the Director of Nursing. Recommendations from the prior month that remain outstanding are escalated in the report to the Director of Nursing for immediate completion. The Director of Nursing will monitor completion of the MRR from the date of delivery until are recommendations are completed including verification of required documentation. The Consultant Pharmacist will report trends identified in timely completion and filing of the MRRs to the Quality Assurance committee during the quarterly QA&A meeting for the purpose of process improvement and to ensure continued compliance with this plan of correction. **Allegation of Compliance Date: 3/25/2025.**	

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F 756	Continued From page 125 Order Summary indicated she was prescribed guaifenesin oral liquid to take 10 ml by mouth every four hours as needed for congestion on 11/30/2024. During a review of the consultant pharmacist's recommendation, dated 11/30/2024, the consultant pharmacist's recommendation indicated the consultant pharmacist advised the facility that PRN orders for lorazepam must be limited to 14 days or a specific duration with a corresponding clinical rationale must be documented. Further review of the pharmacist's recommendation indicated that the facility documented "no new orders" on 12/17/2024. During a review of the consultant pharmacist's recommendation, dated 12/31/2024, the consultant pharmacist's recommendation indicated the consultant pharmacist advised the facility to indicate the length of therapy for PRN guaifenesin oral liquid as the facility's policy for the duration of cough and cold products is limited to 10 days. Further review of the pharmacist's recommendation indicated no apparent facility response. During an interview on 2/26/2025 at 3:27 p.m., with the Director of Nursing (DON), the DON stated the facility failed to timely respond to the pharmacist's recommendation to limit PRN lorazepam to 14 days and define the length of therapy of guaifenesin oral liquid. The DON stated the facility failed to limit the duration of Resident 101's PRN lorazepam to 14 days or document a longer duration and rationale between 5/15/2024 and 2/24/2025. The DON stated the facility also failed to define or limit the use of guaifenesin oral liquid to 10 days per the	F 756		

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F 756	Continued From page 126 facility policy. The DON stated the failure to limit PRN medications per the requirements and recommendations of the pharmacist increased the risk that Resident 101 may have received them when it had become clinically inappropriate. The DON stated the reason for using PRN medications may change with the passage of time and must be limited so they can be periodically reevaluated to determine if the resident still has need for them. The DON stated the failure to limit Resident 101's PRN medications per the requirements also increased the risk that she may have experienced adverse effects related to the medications which could have contributed to a decline in her quality of life. During a review of the facility's policy, Medication Regimen Review, undated, the policy indicated " ...The facility staff will encourage the physician/prescriber or other responsible parties receiving the MRR and the Director of Nursing to act upon the recommendations including acceptance or rejection; and provide an explanation as to why the recommendations was rejected ... The attending physician should address the consultant pharmacist's recommendations no later than their next scheduled visit to the facility to assess the resident ..."	F 756	**F757Drug Regimen is free from Unnecessary Drugs. CFR(s): 483.45(d)(1)-(6)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 101's use of guaifenesin oral liquid was discontinued on 2/27/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents receiving PRN medication without a duration, for a temporary condition such as a cough, are potentially affected by the facility practice. The Director of Medical Records generated an audit of all residents receiving guaifenesin oral liquid to identify residents whose medication does not have a stop date and are potentially affected by the facility practice. A copy of the audit was provided to the audit was provided to the Director of Nursing on 2/27/2025 for further review and analysis.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757	2 residents had orders for guaifenesin oral liquid as needed. 0 of 2 residents were identified without a duration for use. 1 of 2 residents orders were clarified and/or discontinued by the licensed nurse on 3/18/25.	

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F 757	Continued From page 127 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to reevaluate or discontinue a PRN (as needed) order for guaifenesin oral liquid (a medication used to treat cough/congestion) after 10 days in one of five residents sampled for unnecessary medications (Resident 101). The deficient practice of failing to stop or reevaluate PRN medications increased the risk that Resident 101 may have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to the use of guaifenesin possible resulting in a decline in her quality of life. Cross-referenced to F756 Findings: During a review of Resident 101's Admission Record (a document containing a resident's	F 757	No other residents were affected by this deficient practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Medical Records will audit the physician orders for PRN medications monthly to ensure all as needed medications have a duration for use and include a stop date as part of the order. The Director of Nursing/designee will re-educate the nursing staff on or before, 3/21/2025, re: the facility's policy, "Physician Telephone Orders," with emphasis on ensuring orders are complete and include a stop date for as needed medications. The DSD orients new employees upon hire, annually and as needed on completion of physician orders including completing the order to include stop dates for as needed medications to treat temporary conditions. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Medical Records will audit physician orders for as needed medications monthly to ensure orders contain a stop or discontinue date. As needed orders identified without discontinuation or stop dates will be provided to the Director of Nursing for further review and correction. The Director of Nursing will report	

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F 757	Continued From page 128 diagnostic and demographic information), dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 5/15/2024 with diagnoses including: anxiety disorder (a mental illness characterized by persistent worry or fear strong enough to interfere with daily life). During a review of Resident 101's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 1/3/2025, the H&P indicated she had "worsening functional and cognitive decline" but did not indicate whether she had the capacity to understand and make decisions. During a review of Resident 101's Physician Order Summary (a monthly summary of all active physician orders), dated 2/26/2025, the Physician Order Summary indicated she was prescribed guaifenesin oral liquid to take 10 milliliters (ml - a unit of measure for volume) by mouth every four hours as needed for congestion on 11/30/2024. Further review of the order for guaifenesin indicated there was no stop date indicated. During a review of the consultant pharmacist's recommendation, dated 12/31/2024, the consultant pharmacist's recommendation indicated the consultant pharmacist advised the facility to indicate the length of therapy for PRN guaifenesin oral liquid as the facility's policy for the duration of cough and cold products is limited to 10 days. Further review of the pharmacist's recommendation indicated no apparent facility response. During an interview on 2/26/2025 at 3:27 p.m., with the Director of Nursing (DON), the DON stated the facility failed to define or limit the use	F 757	significant trends identified during review of the medical records monthly audit to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction; or for determination of substantial compliance and termination of this plan of correction. Substantial compliance will be demonstrated by three consecutive Quality Assurance reviews without variance to standard findings. **Allegation of Compliance Date:** 3/25/2025	

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F 757	Continued From page 129 of guaifenesin oral liquid to 10 days per the facility policy. The DON stated the failure to limit PRN medications per the requirements and recommendations of the pharmacist increased the risk that Resident 101 may have received them when it had become clinically inappropriate. The DON stated the reason for using PRN medications may change with the passage of time and must be limited so they can be periodically reevaluated to determine if the resident still has need for them. The DON stated the failure to limit Resident 101's PRN medications per the requirements also increased the risk that she may have experienced adverse effects related to the medications which could have contributed to a decline in her quality of life. During a review of the facility's policy "Stop Orders," revised April 2018, the policy indicated "The following classes of medications, whether the order is for routine or as needed (PRN) use, are stopped automatically after the indicated number or days, unless the prescriber specifies a different number of doses or duration of therapy to be given ... cough and cold preparations 10 days."	F 757	**F758 Free From Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)€(1)(5)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1. The IDT completed a gradual dose reduction assessment on Residents 1 and 71 on 2/28/2025. 2. The licensed nurse clarified Resident 101's use of Lorazepam PRN on 2/24/2025. 3. Resident 68's use of antipsychotic medication, Quetiapine, was discontinued on 1/29/25. 4. The licensed nurses are monitoring ad documenting Resident 347's behaviors of "repetitive physical movements and restlessness" related to the use of PRN alprazolam. 5. Resident 347's simultaneous use of sertraline and escitalopram, both used to treat depression, was clarified by the licensed nurse on 2/27/2025. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents with psychotherapeutic medication therapy are potentially affected by the facility practice.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		

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F 758	Continued From page 130 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758	The Director of Nursing/designee audited the physician orders for psychotropic medications of all residents to identify residents who may be potentially affected by the facility practice on 3/6/2025. 35 residents with psychotherapeutic medication therapy were audited. 5 of 35residents required the licensed nurse to clarify the physicians order with resident specific targeted behaviors, stop date, duplicate medication therapy and monitoring of targeted behaviors. The Director of Social Services/designee audited resident records who receive psychotherapeutic medications on 3/6/2025 to identify residents who do not have documented evidence of a gradual dose reduction in the medical record. 35 Residents receiving psychotherapeutic medications were audited. 2 of 35 residents required a gradual dose reduction. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The IDT will review and revise the care plans of all residents with psychotherapeutic medication therapy to ensure care plans include resident specific targeted behaviors and justification for dual medication therapy when indicated on 3/6/2025.	

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F 758	Continued From page 131 Based on interview and record review, the facility failed to: 1. Perform a gradual dosage reduction (GDR - a periodic attempt to lower the dosage of a medication or discontinue a medication in order to control a resident's symptoms with lower doses or fewer medications) for psychotropic medications (medications that affect brain activities associated with mental processes and behavior) in two of five residents sampled for unnecessary medications (Residents 1 and 71.) 2. Limit the duration of PRN (as needed) lorazepam (a medication used to treat mental illness) to 14 days or document a longer, specific duration and clinical rationale in one of five residents sampled for unnecessary medications (Resident 101.) 3. Ensure the antipsychotic medication (a class of medications used to treat mental illness), quetiapine (an antipsychotic medication used to treat mental illness) was used for a clear indication or diagnosed condition as documented in the clinical record for one of five residents sampled for unnecessary medications (Resident 68.) 4. Monitor for the target behaviors of "physical aggression" related to the use of quetiapine in one of five residents sampled for unnecessary medications (Resident 68.) 5. Document behaviors of "repetitive physical movements and restlessness" related to the use of PRN alprazolam (a medication used to treat mental illness) in the February 2025 Medication Administration Record (MAR - a record of all	F 758	The Director of Nursing/designee will re-educate licensed nurses and the IDT on the facility policies and procedures Unnecessary Medications including required gradual dose reduction, justification when dual medication therapy is indicated, ensuring PRN medications have a stop date and monitoring clearly defined behaviors in the medical record on or before 3/21/2025. The Director of Medical Records will audit the orders of residents' psychotropic medications to verify the order includes a stop date for PRN medications, diagnosis, targeted behavior(s) and targeted behavior and provide copies of the audits to the Director of Nursing for tracking and trending analysis and further follow through as needed. The Director of Social Services will monitor resident physician order changes weekly to ensure residents using psychotropic medications have complete physician orders including targeted behaviors, justification for dual medication therapy, stop dates and clearly defined diagnosis to support the use of medication. The IDT will review the orders of residents at the onset of psychotherapeutic medication changes or admission whichever comes first to ensure complete physician orders including targeted behaviors, justification for dual medication therapy, stop dates and clearly defined diagnosis to support the use of medication and to identify opportunities for gradual dose reduction attempts five times weekly during the morning clinical meeting.	

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THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

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F 758	Continued From page 132 medications administered and monitoring documented for a resident) for one of five residents sampled for unnecessary medications (Resident 347.) 6. Ensure sertraline (a medication used to treat depression [a mental illness defined by depressed mood, trouble sleeping, and lack of interest in activities]) and escitalopram (a medication used to treat depression) were not used simultaneously without clinical justification in one of five residents sampled for unnecessary medications (Resident 347.) The deficient practices of failing to perform GDRs, limit the duration of PRN orders for psychotropic medications, use antipsychotics for a clear indication, monitor and document target behaviors, and avoid therapeutic duplication of antidepressant therapy increased the risk that Residents 1, 68, 71, 101, and 347 could have experienced adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: 1.a. During a review of Resident 1's Admission Record (a document containing a resident's diagnostic and demographic information), dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 12/14/2017 and most recently readmitted on 4/14/2022 with diagnoses including: Major Depressive Disorder (MDD - a mental illness defined by depressed mood, trouble sleeping, and lack of interest in	F 758	**D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Staff Development will monitor the completion of staff training during new hire orientation, and as needed on the facility's unnecessary medication policy and procedure. The Pharmacy Consultant shall monitor the medication regimen of residents each month to identify the potential for unnecessary drug use and report the results to the Director of Nursing and QAA quarterly. The Director of Social Services will monitor the Medical Records verification of complete physician orders, track gradual dose reduction attempts and identify opportunities for GDR, and clearly defined diagnosis for use. Variance to standard concerns identified will be reported to the Director of Nursing. The Director of Nursing/designee will report significant trends identified to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 133 activities) and anxiety disorder (a mental illness characterized by persistent worry or fear strong enough to interfere with daily life.) During a review of Resident 1's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 1/22/2025, the H&P indicated she had the capacity to understand and make decisions. During a review of Resident 1's Physician Order Summary (a monthly summary of all active physician orders), dated 2/26/2025, the Physician Order Summary indicated she was prescribed the following: 1. Lorazepam 0.5 milligrams (mg - a unit of measure for mass) by mouth one time a day for "anxiety manifested by inconsolable drying and excessive worrying" on 7/27/2024. 2. Sertraline 50 mg by mouth one time a day for "depression manifested by verbalization of sadness" on 7/27/2024. During a review of the consultant pharmacist's (a medical professional responsible for a monthly review of all residents' medication regimens) recommendations, dated 1/31/2025, the consultant pharmacist's recommendations indicated the pharmacist recommend a GDR for Resident 1's sertraline and lorazepam. Further review of the pharmacist's recommendation indicated the psychiatric nurse practitioner (NP) agreed and indicated to decrease the dosage of sertraline from 50 mg daily to 25 mg daily and to discontinue the lorazepam. During a review of Resident 1's Psychiatric Progress Note (clinical documentation of a psychiatric treatment professional's assessment	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 134	F 758		

and treatment plan), authored by NP and dated 2/24/2025, the Psychiatric Progress Note indicated the plan was to "Decrease sertraline 25 mg oral tablet QD (every day). Discontinue lorazepam tablet 0.5 mg QD. Please refer to updated physician's orders & MAR."

1.b. During a review of Resident 71's Admission Record, dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 7/16/2021 and most recently readmitted on 1/31/2024 with diagnoses including: MDD.

During a review of Resident 71's History and Physical (H&P), dated 11/23/2024, the H&P indicated she had the capacity to understand and make decisions.

During a review of Resident 71's Physician Order Summary, dated 2/26/2025, the Physician Order Summary indicated she was prescribed amitriptyline 50 mg at bedtime for "depression manifested by loss of interested in most normal activities" on 10/23/2024.

During a review of the consultant pharmacist's recommendations, dated 1/31/2025, the consultant pharmacist's recommendations indicated the pharmacist recommend a GDR for Resident 71's amitriptyline. Further review of the pharmacist's recommendation indicated NP agreed and indicated to decrease the dosage of amitriptyline from 50 mg to 25 mg at bedtime.

During a review of Resident 71's Psychiatric Progress Note, authored by NP and dated 2/24/2025, the Psychiatric Progress Note indicated the plan was to "Decrease amitriptyline tablets 25 mg QHS (at bedtime). Please refer to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 135 updated physician's orders & MAR." During an interview on 2/26/2025 at 3:27 p.m. with the Director of Nursing (DON), the DON stated the pharmacist's recommendations on 1/31/2025 indicated NP responded to a GDR request for Resident 1's sertraline to decrease the dose from 50 mg daily to 25 mg and to discontinue the lorazepam and to decrease Resident 71's dose of amitriptyline from 50 mg to 25 mg at bedtime. The DON stated, according to the NP's psychiatric notes, dated 2/24/2025, NP's plan was to decrease Resident 1's sertraline from 50mg to 25 mg and discontinue the lorazepam and to reduce Resident 71's dose of amitriptyline from 50 mg to 25 mg at bedtime. The DON, stated, despite these records, the facility failed to implement the changes in dose and Resident 1 was still receiving 50 mg of sertraline and still had an active order for lorazepam and Resident 71 was still receiving 50 mg of amitriptyline because NP had not yet issued the new orders. The DON stated no one from the facility followed up with NP after reviewing the response to the pharmacist's recommendations or the psychiatric notes indicating the GDRs to obtain any needed orders. The DON stated, as a result, the facility failed to implement the gradual dosage reduction of Resident 1's sertraline from 50mg to 25mg or discontinue the lorazepam or to decrease Resident 71's dosage of amitriptyline from 50 mg to 25 mg at bedtime. The DON stated using sertraline, lorazepam, or amitriptyline at a higher dose than necessary increased the risk that Residents 1 and 71 may have experienced adverse effects including drowsiness, dizziness, dry mouth, or fall with injury possibly leading to a decline in their functional status or quality of life.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 136 2. During a review of Resident 101's Admission Record, dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 5/15/2024 with diagnoses including: anxiety disorder (a mental illness characterized by persistent worry or fear strong enough to interfere with daily life.) During a review of Resident 101's H&P, dated 1/3/2025, the H&P indicated she had "worsening functional and cognitive decline" but did not indicate whether she had the capacity to understand and make decisions. During a review of Resident 101's Order Audit Report (a report containing details and a timeline regarding a specific physician order), dated 2/26/2025, the Order Audit Report indicated she was prescribed lorazepam 2 mg per milliliter (ml - a unit of measure for volume) oral concentrate to take 1 ml by mouth every four hours as needed for anxiety between 5/15/2024 and 2/24/2025. During a review of the consultant pharmacist's recommendation, dated 11/30/2024, the consultant pharmacist's recommendation indicated the consultant pharmacist advised the facility that PRN orders for lorazepam must be limited to 14 days or a specific duration with a corresponding clinical rationale must be documented. Further review of the pharmacist's recommendation indicated that the facility documented "no new orders" on 12/17/2024. During an interview on 2/26/2025 at 3:27 p.m., with the DON, the DON stated the facility failed to timely respond to the pharmacist's recommendation to limit PRN lorazepam to 14 days. The DON stated the facility failed to limit the	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 137	F 758		

duration of Resident 101's PRN lorazepam to 14 days or document a longer duration and rationale between 5/15/2024 and 2/24/2025. The DON stated the failure to limit PRN medications per the requirements and recommendations of the pharmacist increased the risk that Resident 101 may have received them when it had become clinically inappropriate. The DON stated the reason for using PRN medications may change with the passage of time and must be limited so they can be periodically reevaluated to determine if the resident still has need for them. The DON stated the failure to limit Resident 101's PRN medications per the requirements also increased the risk that she may have experienced adverse effects related to the medication which could have contributed to a decline in her quality of life.

3. During a review of Resident 68's Admission Record, dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 1/22/2025 with diagnoses including: dementia (a group of progressive medical conditions affecting the brain that interfere with the ability to remember, think clearly, and make decisions.)

During a review of Resident 68's H&P, dated 1/24/2025, the H&P indicated she did not have the capacity to understand and make decisions.

During a review of Resident 68's Order Audit Report, dated 2/26/2025, the Order Audit Report indicated she was prescribed quetiapine 75 mg by mouth at bedtime for "adjunct treatment of depression manifested by physical aggression" between 1/22/2025 and 1/29/2025.

During a review of Resident 68's MAR, for January 2025, the MAR indicated she received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 138	F 758		

quetiapine 75 mg from 1/23/2025 to 1/28/2025. Further review of the MAR indicated the behavioral monitoring order related to Resident 68's quetiapine instructed licensed staff to monitor for "verbal aggression" rather than "physical aggression."

During a review of Resident 68's Psychiatric Progress Note, authored by NP and dated 1/23/2025, the Psychiatric Progress Note indicated there was no discussion of Resident 68's need for adjunct treatment of depression (combining an antidepressant and an antipsychotic to better treat depression) with an antipsychotic medication including Resident 68's history of antidepressants tried and failed or any rationale for the combination therapy without having optimized the dose of her antidepressant first.

During a review of Resident 68's clinical record, the clinical record indicated no other documented rationale for the use of quetiapine or any medical or psychiatric history documenting the need for adjunct treatment for MDD.

During a review of Resident 68's Psychiatric Progress Note, authored by NP and dated 1/29/2025, the Psychiatric Progress Note indicated to discontinue Resident 68's quetiapine.

During a telephone interview, on 2/27/2025, at 8:56 a.m., with NP, NP stated he was not aware of Resident 68 needing quetiapine as adjunct therapy for MDD. NP stated this medication should not have been continued upon her admission to the facility as it was being given for "agitation or anxiety" during her hospital stay prior to her admission to the facility. NP stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 139 quetiapine was discontinued because the resident has dementia and to continue using this medication regularly put this resident at risk for sedation, dizziness, drowsiness, increased risk of fall with injury, and unexplained death or stroke which outweighed any benefit she may have received from it. During an interview on 2/27/2025 at 9:20 a.m. with the DON, The DON stated when an antipsychotic medication is prescribed, it must have a clear indication and diagnosis documented in the resident's clinical record. The DON stated the facility failed to ensure Resident 68 had a clear indication for the use of quetiapine upon her admission to the facility. The DON stated Resident 68's behaviors related to MDD included "loss of interest or pleasure in normal activities." The DON stated the target behaviors for using the quetiapine were "physical aggression." The DON stated, if quetiapine was used as "adjunct therapy" to help sertraline better treat the symptoms of MDD, it doesn't make sense that it would have different target behaviors. The DON stated, because the use of quetiapine was not clearly defined in Resident 68's clinical record, the risks of continued quetiapine use, including dizziness, drowsiness, fall with injury and death, were increased and outweighed any benefits. The DON stated the facility failed to properly monitor for target behaviors related to the use of quetiapine. The DON stated the target behavior defined for the use of quetiapine for Resident 68 was "physical aggression", however, according to the January 2025 MAR, the facility was monitoring for behaviors of "verbal aggression." The DON stated, the monitoring order did not include the correct behaviors for which quetiapine was	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 140	F 758		

prescribed. The DON stated this may cause licensed nurses to not document episodes of "physical aggression" despite the resident exhibiting them. The DON stated it is important to properly monitor target behaviors related to antipsychotic use in order to periodically reassess whether the medication is effective at controlling those behaviors. The DON stated, if behaviors are not properly monitored, there is a risk that the resident may receive antipsychotic therapy for longer or at higher doses than necessary possibly leading to increased adverse effects of quetiapine and a decline in quality of life.

4. During a review of Resident 347's Admission Record, dated 2/27/2025, the Admission Record indicated she was admitted to the facility on 2/2021/2025 with diagnoses including: depression and anxiety.

During a review of Resident 347's clinical record, the clinical record indicated she did not yet have a History and Physical on file with the facility.

During a review of Resident 347 Order Summary Report, dated 2/27/2025, the Order Summary Report indicated she was prescribed the following:
1. Alprazolam 0.5 mg by mouth every six hours as needed for "anxiety manifested by repetitive physical movements as evidenced by restlessness" on 2/2021/2025.
2. Escitalopram 10 mg by mouth one time a day for "depression manifested by loss of interest in most normal activities" on 2/24/2025.
3. Sertraline 50 mg by mouth one time a day for "depression manifested by loss of interest or pleasure in most or all normal activities" on 2/2021/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 141 During a review of Resident 347's MAR, for February 2025, the MAR indicated she received PRN alprazolam on 2/22, 2/23, and 2/24/2025, however, the behavioral monitoring order Related to Resident 347's alprazolam indicated there were no documented incidents of Resident 347 having "repetitive physical movements as evidenced by restlessness" on those days or at any other time during February 2025. During a review of Resident 347's Psychiatric Progress Note, authored by NP and dated 2/24/2025, the Psychiatric Progress Note indicated Resident 347 was to receive both escitalopram and sertraline, but provided no discussion or rationale as to why Resident 347 would need two antidepressants of the same class simultaneously. During a review of Resident 347's clinical record, the clinical record indicated there was no other documented clinical rationale for the use of both escitalopram and sertraline simultaneously. During a telephone interview on 2/27/2025 at 8:56 a.m. with NP, NP stated it is not appropriate for Resident 347 to be on both escitalopram and sertraline at the same time. NP stated these medications are in the same class of antidepressant and are not commonly used at the same time. NP stated, on 2/24/2025, after seeing Resident 347, the resident stated she wanted to try a different antidepressant than sertraline. NP stated he gave the facility staff a verbal discontinue order for sertraline and prescribed escitalopram. NP stated it is possible this order was not communicated to the facility staff effectively. NP stated he was unaware that	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 142 Resident 347 was receiving them simultaneously. NP stated using them together could cause additional adverse effects related to their use which could decrease Resident 347's quality of life. During an interview on 2/27/2025 at 9:20 a.m. with the DON, the DON stated Resident 347's order for alprazolam is for PRN use so it should only be used when the resident is experiencing the symptoms or behaviors for which it is prescribed. The DON stated the February MAR between 2/2021 and 2/2025 indicate this resident did not have any behaviors of "Anxiety manifested by repetitive physical movements as evidenced by restlessness" documented. The DON stated the February MAR also indicated that Resident 347 received alprazolam on 2/22, 2/23, and 2/24. The DON stated, although the licensed nurses are documenting the administration of PRN doses of alprazolam in the nurses' progress notes, they failed to document the behaviors on the behavioral monitoring order in the MAR. The DON stated it is important to document the behaviors in the MAR because the prevalence of behaviors documented there is used to determine if a medication is effective at controlling those behaviors. The DON stated, without documenting behaviors in the MAR, the medication cannot accurately be reevaluated to determine whether it is controlling Resident 347's symptoms of anxiety. The DON stated this could possibly result in the resident receiving a decrease in dosage or a discontinuation of the medication, resulting in a worsening of her anxiety and a decline in her quality of life. During a review of the facility's policy titled, "Psychotropic Medication - Gradual Reduction	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 143	F 758		

and PRN," revised March 2023, the policy indicated "Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record ... The facility implements gradual dose reductions (GDR) ... unless contraindicated, prior to initiating or instead of continuing psychotropic medication ... PRN orders for psychotropic drugs are limited to 14 days, unless the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days ... the attending physician or prescribing practitioner shall document their rationale in the resident's medical record and indicate the duration for the PRN psychotropic order when the order extends beyond 14 days ..."

During a review of the facility's policy titled, "Antipsychotic Medications Use in Dementia," revised March 2023, the policy indicated "Antipsychotic medication therapy for residents with dementia shall be used only when it is necessary to treat a specific medical condition ... Residents with dementia will only receive antipsychotic medication when necessary to treat specific conditions for which they are indicated and effective ... nursing staff will document in detail and individual's target symptoms ... the staff will observe, document, and report to the Attending Physician information regarding the effectiveness or any interventions, including antipsychotic medications ..."

During a review of the facility's policy titled, "Stop Orders," revised April 2018, the policy indicated "The following classes of medications, whether the order is for routine or as needed (PRN) use,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ELLISON JOHN TRANSITIONAL CARE CENTER	43830 10TH STREET WEST LANCASTER, CA 93534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 144 are stopped automatically after the indicated number or days, unless the prescriber specifies a different number of doses or duration of therapy to be given ... PRN anxiolytics ... 14 days."	F 758	**F760** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber ' s order, manufacturer ' s specifications, and accepted professional standards) for three of three sampled residents (Residents 65, 29 and 52) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) and anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin and heparin (an anticoagulant) administration sites for (Residents 65, 29 and 52). The deficient practice had the potential to result in an adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin and heparin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which	F 760	Licensed Nurses are rotating injection sites for Resident 65, 29 and 52 and all residents who receive routine injections. 1. Resident 197 discharged on 3/4/25. Resident's MD declined to have thyroid hormone level checked after the discovery of missed doses. 2. MD was notified about the missed doses on 2/28/25 with no new orders. 3. Licensed nurses are administering Resident 197's Levothyroxine in accordance with physician order. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents receiving routine injections in the same injection sites and who are not administered medications per physician order are potentially affected. The Director of Nurses/designee audited residents who receive routine injections 2/15-2025 through 2/25/2025 to identify other residents who may be affected by the facility practice.	

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 760	Continued From page 145 clumps of abnormal proteins called amyloids build up in the skin). Additionally, the facility failed to ensure to administer three doses of levothyroxine as ordered for one of one sampled resident (Resident 197) reviewed for levothyroxine use. This deficient practice had the potential to result in adverse effects (unwanted, unintended result) and serious health complications such as heart problems and impaired cognitive function. Cross reference F658 Findings: a. During a review of Resident 65 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/8/2021 and readmitted the resident on 1/10/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), long term use of insulin, and generalized muscle weakness. During a review of Resident 65 ' s History and Physical (H&P) dated 1/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/17/2025, the MDS indicated Resident 65 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required partial/moderate assistance with toileting hygiene,	F 760	The Director of Nurses/designee audited residents who receive routine injections 2/15-2025 through 2/25/2025 to identify other residents who may be affected by the facility practice. The Director of Nursing audited residents who receive Levothyroxine on 3/21/2025 to identify residents who did not receive the medication. A total of 19 residents receive Levothyroxine. 19 of 19 resident records accurately reflect doses remaining indicating residents received their medication. Resident injection sites were rotated; and no other residents were identified as affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Director of Staff Development/designee will re-educate the licensed nurses re: the facility policy and procedure, "Diabetes Management," with emphasis on rotation of injection sites to avoid tissue damage from repeated injections on or before 3/21/2025. The DSD/designee will complete weekly audits of residents receiving subcutaneous injections to ensure licensed nurses are rotating injection sites routinely to ensure residents do not experience tissue damage to the extent possible. The DSD/designee will run an injection administration	

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F 760	Continued From page 146 bathing, and lower body dressing; substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 65 received insulin. During a review of Resident 65 ' s care plan (CP) titled "Risk for hypoglycemia (low blood sugar)/hyperglycemia (high blood sugar) relate to diagnosis of DM 2 initiated on 1/13/2025 and last revised on 1/24/2025, the CP indicated to administer insulin lispro injection as ordered per sliding scale as one of the interventions to minimize complications related to DM 2. During a review of Resident 65 ' s Order Summary Report, the Order Summary Report indicated the following physician ' s orders 1/28/2025: Insulin lispro injection solution (a short acting insulin) 100 unit per milliliter (unit/ml) inject subcutaneously before meals and at bedtime for DM 2. Fingerstick blood sugar (FSBS - most common type of blood sugar monitoring) using lancets (a small needle) and test strips. Rotate injection site. Inject as per sliding scale (increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal): if 70 - 149 = 0 units; if BS less than (<) 70 and awake give juice; if unresponsive, give Glucagon (a hormone that raises blood sugar) 1 milligram (mg - a unit of measurement) intramuscularly (IM - inject into the muscle) and notify physician (MD); 150 - 199 = 4 units; 200 - 249 = 8 units; 250 - 299 = 12 units; 300 - 349 = 16 units; 350 plus = 20	F 760	audit through PCC weekly to audit . Concerns identified will be reported to the Director of Nursing for further review, analysis, and follow-up. The Director of Staff Development will re-educate licensed nurses on the facility policy and procedure, Physician Orders," with emphasis on following physician orders including ordered time and frequency of administration on or before 3/21/2025. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Consultant Pharmacist monitors licensed nurses' proper administration of medication during routine facility audits and reports the findings to the QAA Committee, at a minimum quarterly for the purpose of process improvement. The Director of Nursing will monitor the DSD audits of resident subcutaneous injection sites by licensed nurses to ensure sites are rotated to mitigate tissue damage to the extent possible and to identify continued compliance or the need for further education or progressive disciplinary action. The Director of Medical records/designee will audit the administration times of residents with Levothyroxine orders to ensure residents receive medication during acceptable timeframe for medication administration, monthly. Results of the medication administration audit will be given to	

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F 760	Continued From page 147 units and notify MD. During a concurrent interview and record review on 2/27/2025 at 12:22 p.m., Resident 65 ' s physician ' s orders, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report for 2/2025 was reviewed with Licensed Vocational Nurse 3 (LVN 3). LVN 3 stated Resident 65 had a physician ' s order for insulin lispro which was administered as follows: Insulin lispro injection solution 100 unit/ml: 2/02/25 10:19 p.m. subcutaneously abdomen - left lower quadrant (LLQ) 2/03/25 4:29 p.m. subcutaneously abdomen - LLQ 2/03/25 11:31 subcutaneously abdomen - LLQ 2/06/25 4:54 p.m. subcutaneously abdomen - right lower quadrant (RLQ) 2/06/25 8:02 p.m. subcutaneously abdomen - RLQ 2/08/25 12:25 p.m. subcutaneously abdomen - LLQ 2/08/25 4:08 p.m. subcutaneously abdomen - LLQ 2/12/25 8:26 p.m. subcutaneously abdomen - RLQ 2/13/25 5:59 a.m. subcutaneously abdomen - RLQ 2/15/25 11:43 a.m. subcutaneously abdomen - LLQ 2/15/25 5:26 p.m. subcutaneously abdomen - LLQ LVN 3 stated insulin administration sites should be rotated per standards of practice, manufacturer ' s guidelines, and according to physician ' s orders. LVN 3 stated Resident 65 ' s	F 760	the Director of Nursing for further review, analysis and follow-up as indicated. Compliance concerns identified will be corrected immediately and reported to the Director of Nursing for further corrective action as indicated. Trends identified in the injection site rotation audits will be reported by the Director of Staff Development to the Quality Assurance committee during the quarterly QA&A meeting for the purpose of process improvement changes to ensure continued compliance with this plan of correction/. **Allegation of Compliance Date 3/25/2025**	

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F 760	Continued From page 148 MAR indicated the insulin administration sites were not rotated and there was a physician ' s order to rotate injection sites. LVN 3 stated Resident 65 ' s insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident ' s skin. During an interview on 2/28/025 at 1 p.m. Resident 65 ' s physician ' s orders, MAR Location of Administration Report for 2/2025 was reviewed with the Director of Nursing (DON). The DON stated the location of administration sites for Resident 65 ' s insulin was not rotated. The DON stated the charge nurses (CN) are required to rotate the insulin administration sites according to standards of practice, as indicated in the manufacturer ' s guideline, and physician ' s order. The DON stated Resident 65 had a physician ' s order to rotate injection sites. The DON stated Resident 65 ' s administration sites for insulin should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. The DON stated not rotating the administration sites of insulin can be considered a medication error due to not following the MD orders, manufacturer ' s guideline, and professional standards of practice. b. During a review of Resident 29 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 1/22/2025, with diagnoses including type 2 diabetes mellitus (a disorder in which the body does not produce enough or respond normally to insulin, causing	F 760		

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F 760	Continued From page 149 blood sugar [glucose] levels to be abnormally high), peripheral vascular disease (the reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), and atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls). During a review of Resident 29 ' s History and Physical (H&P), dated 1/23/2025, the H&P indicated the resident was on DVT (DVT, a blood clot in a vein deep in the body, usually in the leg) prophylaxis (an attempt to prevent disease) heparin subcutaneous (sq, beneath, or under, all the layers of the skin) and the resident had the ability to make self-understood and understand others. During a review of Resident 29 ' s Minimum Data Set (MDS, a resident assessment tool), dated 1/29/2025, the MDS indicated the resident had the ability to make self-understood and to understand others and had intact cognition (person's cognitive abilities like memory, understanding, problem-solving etc. are working usually in all fundamental ways). The MDS indicated the resident was on an anticoagulant and hypoglycemic medications (a class of drugs that help lower blood sugar levels). During a review of Resident 29 ' s Order Summary Report, the Order Summary Report indicated an order as follows: 1/22/2025 Heparin Sodium (Porcine) Injection Solution 5000 unit per milliliters (unit [s an amount approximately equivalent to 0.002 mg of pure heparin]/ml [a unit of volume]) (Heparin Sodium (Porcine)). Inject 1 milliliter subcutaneously three times a day for DVT	F 760		

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F 760	Continued From page 150 prophylaxis. Rotate injection sites. 1/22/2025 Heparin: Monitor for signs and symptoms of bleeding (abnormal or unexplained bruising, petechiae (small red or purple spots on the skin or inside the mouth that are caused by broken blood vessels), internal bleeding, nosebleeds, bleeding gums, abnormal bleeding) by (+)YES or(-)NO. Notify MD if (+). Every shift. 1/27/2024 Humulin R Injection Solution 100 unit/ml (Insulin Regular [Human]). Inject as per sliding scale (the increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal.): if 70 - 149 = 0, If blood sugar (BS) is less than 70 & awake, given orally (PO) juice. If unresponsive give Glucagon (a hormone that raises blood sugar [glucose]) 1 milligram (mg, a unit of weight) intramuscular (IM, within or into the muscle), notify MD. 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 4 units; 300 - 349 = 5 units; 350+ = 6 units Notify MD, subcutaneously before meals and at bedtime for Type 2 diabetes mellitus rotate injection site. During a review of Resident 29 ' s Location of Administration Report of Humulin R and Heparin Sodium for 1/2025 to 2/2025, the Location of Administration Report indicated Heparin Sodium (Porcine) Injection Solution 5000 unit/ml was administered subcutaneously on: 1/24/2025 at 9:03 p.m. on the abdomen - Left Lower Quadrant (LLQ) 1/25/2025 at 6:37 a.m. on the abdomen - LLQ And Humulin R Injection Solution 100 unit/ml was administered subcutaneously on: 1/29/2025 at 5:33 a.m. on the abdomen - LLQ 1/29/2025 at 12:23 p.m. on the abdomen - LLQ 2/14/2025 at 8:22 p.m. on the abdomen - Left Upper Quadrant (LUQ) 2/15/2025 at 8:46 p.m. on the abdomen - LUQ	F 760		

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F 760	Continued From page 151 During a concurrent interview and record review on 2/26/2025, at 8:47 a.m., with Registered Nurse (RN) 1, Resident 29 ' s Location of Administration Report for Humulin R and Heparin Sodium for 1/2025 to 2/2025 were reviewed. RN 1 stated there were multiple instances where the licensed staff did not rotate the subcutaneous administration of heparin and Humulin R on the resident. RN 1 stated it was important to rotate heparin and Humulin R administration sites to prevent excessive bruising and lipodystrophy on residents. RN 1 stated not rotating Humulin R and Heparin Sodium subcutaneous administration sites is a medication error. During an interview on 2/28/2025, at 9:04 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated Resident 29 ' s Humulin R and heparin subcutaneous administration sites to prevent adipose tissue (a connective tissue that extends throughout your body) buildup on the frequented site, discoloration, and hardening of the skin which can affect absorption of the medication. The DON added there was no reason for the licensed staff to repeat administration sites as it appears on the electronic healthcare record where the last subcutaneous administration of heparin and Humulin R was given. The DON stated not rotating Humulin R and Heparin Sodium subcutaneous administration sites is a medication error. c. During a review of Resident 52 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 6/6/2024, with diagnoses including type 2 diabetes mellitus, gastro-esophageal reflux disease (GERD, a	F 760		

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F 760	Continued From page 152 condition where stomach acid flows into the esophagus), and dysphagia (swallowing difficulties). During a review of Resident 52 ' s H&P, dated 6/21/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 52 ' s MDS, dated 12/17/2024, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognitive skills (a condition that makes it difficult for someone to think, learn, remember, and make decisions) for daily decision making. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 52 ' s Order Summary Report, dated 2/22/2025, the Order Summary Report indicated an order of Insulin NPH (Human) (Isophane) Subcutaneous Suspension Pen-injector 100 unit/ml (Insulin NPH [Human] [Isophane]). Inject 18 units subcutaneously two times a day for diabetes/hyperglycemia (a condition in which there is too much glucose in the blood, also known as high blood sugar). Rotate injection sites, hold for blood sugar (BS) less than (<) 100. During a review of Resident 52 ' s Location of Administration Report of Insulin NPH (Isophane) for 1/2025 to 2/2025, the Location of Administration Report indicated Insulin NPH (Isophane) Subcutaneous Suspension Pen-Injector 100 unit/ml was administered on: 1/5/2025 at 5:10 a.m. on the abdomen - LLQ 1/5/2025 at 6:04 p.m. on the abdomen - LLQ	F 760		

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F 760	Continued From page 153 1/19/2025 at 5:11 a.m. on the abdomen - LLQ 1/19/2025 at 5:05 p.m. on the abdomen - LLQ 2/7/2025 at 5:08 p.m. on the abdomen - Right Lower Quadrant (RLQ) 2/8/2025 at 6:55 a.m. on the abdomen - RLQ During a concurrent interview and record review on 2/26/2025, at 8:55 a.m., with RN 1, Resident 52 ' s Location of Administration Report for Insulin NPH (Isophane) for 1/2025 to 2/2025. RN 1 stated there were multiple instances where the licensed staff did not rotate the subcutaneous administration of Insulin NPH (Isophane) on the resident. RN 1 stated it was important to rotate Insulin NPH (Isophane) administration sites to prevent excessive bruising and lipodystrophy on residents. RN 1 stated not rotating Insulin NPH (Isophane) subcutaneous administration sites is a medication error. During an interview on 2/28/2025, at 9:04 a.m., with the DON, the DON stated the licensed staff should have rotated Resident 52 ' s Insulin NPH (Isophane) subcutaneous administration sites to prevent adipose tissue buildup on the frequented site, discoloration, and hardening of the skin which can affect absorption of the medication. The DON added there was no reason for the licensed staff to repeat administration sites as it appears on the electronic healthcare record where the last subcutaneous administration of Insulin NPH (Isophane) was given. The DON stated not rotating Insulin NPH (Isophane) subcutaneous administration sites is a medication error. d. During a review of Resident 197 ' s Admission Record, the Admission Record indicated the	F 760		

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F 760	Continued From page 154 resident was admitted on 2/17/2025 with diagnoses including presence of left artificial hip joint, hypertensive heart disease (high blood pressure), and hypothyroidism. During a review of Resident 197 ' s physician order, dated 2/17/2025, the physician order indicated levothyroxine sodium oral tablet 75 micrograms (mcg-a unit of measurement) give one tablet by mouth one time a day for hypothyroidism. During a review of Resident 197 ' s H&P, dated 2/18/2025, the H & P indicated the resident had the capacity to understand and make decisions. During a review of Resident 197 ' s Care Plan Report, dated 2/18/2025, the Care Plan Report indicated the care plan focus indicated the resident has hypothyroidism and required daily thyroid replacement. The Care Plan Report interventions included to give thyroid replacement therapy as ordered and to monitor or document for side effects and effectiveness done by the licensed nurses. During an interview on 2/24/2025 at 10:18 a.m. with Resident 197, Resident 197 stated she has been here since 2/17/2025 and she has only received her thyroid medication only two to three times this week. Resident 197 stated she has not received her thyroid medication this morning. During a concurrent observation and interview on 2/27/2025 at 6:23 a.m. with Licensed Vocational Nurse (LVN) 1 in Nursing Station 1, Resident 197 ' s levothyroxine bubble pack (a card that packages doses of medication within small, clear, or light-resistant amber-colored plastic bubbles	F 760		

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F 760	Continued From page 155 (or blisters). Each pack is secured by a strong, paper-backed foil that protects the pills until dispensed) inside the medication cart. LVN 1 stated the levothyroxine 75 mcg tablet bubble pack was filled on 2/17/2025 with a total of five (5) doses/tablets which were administered. LVN 1 stated he has not administered today ' s dose yet because resident prefers to receive it at 7 a.m. During a concurrent interview and record review on 2/28/2025 at 7:17 a.m. with LVN 1, Resident 197 ' s Medication Administration Record (MAR), dated 2/1/2025 - 2/28/2025 was reviewed. The MAR indicated, a total of 10 doses of levothyroxine were administered from 2/18/2025 to 2/28/2025. LVN 1 stated, there was a total of 15 doses in the bubble pack and 8 tablets were still in the bubble pack. LVN 1 stated there were three (3) tablets that were not administered. LVN 1 stated when Resident 197 ' s levothyroxine are not administered the resident could have confusion. During an interview on 2/28/2025 at 8:47 a.m. with the Director of Nursing (DON), the DON stated Resident 197 ' s medication should be administered as ordered and it is given to treat specific diseases and be monitored. The DON stated when medication is not administered it could affect Resident 197 ' s thyroid functioning. The DON stated LVN 1 should call the doctor and family/representative to inform them about what happened. The DON stated if the doctor will order a thyroid test the licensed nurse will carry out the order and monitor the resident for any changes. The DON stated this is a medication error and entails a change in condition.	F 760		

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 760	Continued From page 156 During a review of the facility provided undated manufacturer ' s guideline for insulin lispro, the manufacturer ' s guideline indicated: - Change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. - Choose your injection site: insulin lispro is injected under the skin of your stomach area, buttocks, upper legs or upper arms. During a review of the facility's recent policy and procedure titled "Medication Errors," last reviewed on 12/3/2024, the P&P indicated "Medication error: The observed or identified preparation or administration of medications or biologicals which is not in accordance with: a. The prescriber's order. b. Manufacturer's specifications regarding the preparation and administration of the medication or biological; or c. Accepted professional standards and principles which apply to professionals providing services. d. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils. During a review of the facility's recent policy and procedure (P&P) titled "Medication Errors," last reviewed on 12/3/2024, the P&P indicated a	F 760		

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F 760	Continued From page 157 medication error is the observed or identified preparation or administration of medications or biologicals which is not in accordance with: a. The prescriber's order. b. Manufacturer's specifications regarding the preparation and administration of the medication or biological; or c. Accepted professional standards and principles which apply to professionals providing services. d. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils. During a review of the facility's recent policy and procedure (P&P) titled "Insulin Administration," last reviewed on 12/3/2024, the P&P indicated the injection sites should be rotated to reduce the risk of damaging the skin tissue. During a review of the facility-provided Highlights of Prescribing Information on the use of Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982, the Highlights of Prescribing Information indicated subcutaneous injection: inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Highlights of prescribing Information on the use of Heparin Sodium Injection, USP for intravenous or subcutaneous use, with initial U.S. approval in 2009, the Highlights of Prescribing Information indicated under method of administration for deep subcutaneous (intrafat) injection, a different site	F 760		

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F 760	Continued From page 158 should be used for each injection to prevent the development of massive hematoma. During a review of the facility-provided Consumer Information on the use of Humulin N vials insulin isophane, human biosynthetic (rDNA origin), suspension for injection, 100 units/mL, the Consumer Information indicated to avoid tissue damage (skin thinning, skin thickening, or skin lumps). always change the site for each injection by at least 1.5 cm (0.5 inches) from the previous site, rotating sites of the body so that the same site is not used more that approximately once a month. Do not inject into pits (depressions), thickened skin or lumps.	F 760	**F791 Routine/Emergency Dental Services in NFs CFR(s): 483.55(b)(1)-(5)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Director of Social Services arranged dental services for Resident 89 and she was examined by the dentist on 3/6//2025.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791	**B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents with dental service needs are potentially affected by the facility practice. The Director of Social Services audited long-term resident records to identify residents who had not been seen by the dentist within the last 12 months on 3/24/25. A total of 47 resident records were reviewed. 3 of 47 residents had not been evaluated during the prior 12 months by the dentist. These residents were interviewed to identify any emergent dental needs. No residents requested an emergency dental visit.	

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F 791	Continued From page 159 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promptly provide dental services for one out of three sampled residents (Residents 89) investigated under dental services by failing to schedule a dental appointment for Resident 89. This deficient practice placed Resident 89 at risk for a delay in the necessary dental and services the resident needs which result in the inability to pain, effectively chew foods, weight changes, lack of energy and loss of muscle mass. Findings: During a review of Resident 89 ' s Admission Record, the Admission Record indicated the	F 791	The Director of Social Services placed 1 residents who had not received an annual routine dental visit on the dentist list for evaluation 3/28/2025. No other residents were affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Administrator re-educated the Director of Social Services re: the facility policy and procedure, "Dental Services," emphasizing resident requests for dental exams must be scheduled during the next routine dentist visit, as soon as possible if the dental need is emergent on 3/24/2025. The Director of Social Services will create a log of all residents and their dental visits including requests for additional services by the dentist when needed. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Director of Social Services will maintain a log of all residents and their dental visits including requests for additional services by the dentist when needed. The Director of Social Services will use the log to monitor the exams and request for further dental needs of the residents including the date the	

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F 791	Continued From page 160 facility originally admitted the resident on 1/16/2024 and readmitted the resident in the facility on 11/18/2024 with diagnoses including rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility) multiple sites, age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and generalized muscle weakness. During a review of Resident 89 ' s History and Physical (H&P), dated 11/19/2024, the H&P indicated Resident 89 had fluctuating capacity to understand and make decisions. During a review of Resident 89 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/30/2024, the MDS indicated Resident 83 had intact cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; partial/moderated assistance to substantial/maximal assistance from staff with all other activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 89 ' s Order Summary Report, dated 11/18/2024, the Order Summary Report indicated a physician ' s order for social services to arrange for dental consult as needed. During an interview, on 2/24/2025, at 10:52 a.m., inside Resident 89 ' s room, Resident 89 stated that she had requested routine dental care from the social services department about three months ago. Resident 89 stated she had mentioned during one of the meetings and did not	F 791	exam is completed and any further follow-up needed. The Director of Social Services will report trends identified in the timely completion of dental visits for residents to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date: 3/25/2025**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 791	Continued From page 161	F 791		

hear back from the social services department. Resident 89 was unable to remember the last time she was seen by the dentist.

During an interview, on 2/25/2025, at 1:20 p.m., with Social Services Assistant (SSA) 1, SSA 1 stated the dentist comes to the facility one (1) to two (2) times a month and residents are seen based on the current list of residents provided by the facility prior to each visit to determine which residents were not seen yet. SSA 1 stated some residents are not seen by the dentist due to resident insurance not paying for services to be provided in the facility. SSA 1 stated the social services department makes arrangements for resident ' s dental appointments if not covered by the insurance in the facility. SSA 1 stated Resident 89 ' s insurance denied the authorization and they have not arranged her dental appointment. SSA 1 stated they should have arranged for Resident 89 ' s dental appointment as previously requested and update the resident as needed so Resident 89 would be aware of the plan for her dental care. SSA 1 stated she spoke with Resident 89 in the afternoon of 2/24/2025 about her dental appointment and did not document her conversation with the resident.

During a concurrent interview and record review, on 2/28/2025, at 9:09 a.m., the with Social Services Director (SSD), Resident 89 ' s social services notes and physician orders were reviewed. The SSD confirmed and stated there was a physician ' s order for dental consultation as needed and there was no documentation of the conversation by the social services department regarding dental care or appointments with Resident 89. The SSD stated if

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F 791	Continued From page 162 a resident ' s insurance does not cover dental services in the facility, the case manager will obtain authorization from the resident ' s insurance, and the social services department will make an appointment and arrange transportation to and from a dental services clinic. The SSD stated SSA 1 should have notified the case manager to obtain authorization for Resident 89 ' s needed dental services so Resident 89 ' s request for dental services can be arranged timely. The SSD stated not meeting Resident 89 ' s dental services needs placed Resident 89 at risk for a delay in the necessary care and services the resident needed, which may lead to pain, difficulty chewing, and being unable to eat. During a review of the facility ' s policy and procedure (P&P) titled, "Dental Services," last reviewed 12/3/2024, the P&P indicated the facility assists residents in obtaining needed dental services including routing and emergency services to meet the needs of each resident. The P&P further indicated: The facility will ensure the dentist provides dental services in accordance with professional standards of quality and timeliness. The facility shall attempt to find alternative funding sources or alternative service delivery systems for residents unable to pay for needed dental services. When necessary, or if requested by the resident or their interested party, the facility will assist the resident in making appointments and arrange for transportation to and from the dental services location.	F 791	**F806 Resident Allergies Preferences Substitutes CFR(s): 483.60(d)(4)(5)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 59 is receiving his meals per his choices and preferences. The Dietary Services Supervisor completed a Food Preferece Evaluation to identify Resident 59's food likes and dislikes to ensure Resident 59 is served meals according to her preference on 2/28/2025. The Dietary Service Department updated Resident 59's tray card with his current food likes and dislikes to ensure she is served meals according to his preferences. The Dietary Services Department updated Resident 59's tray card with her current food likes and dislikes to ensure she is served meals according to her preferences.. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents not meals per their preferences are potentially affected. The Social Service Director audited resident grievance January 1 through	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 806	Continued From page 163 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to honor resident dietary preferences for one of eight sampled residents (Resident 59) reviewed under the Food care area by failing to ensure the resident was not served fish, a disliked food, at lunch on 2/28/2025. This deficient practice had the potential to result in the resident having a decreased meal intake which could lead to unintentional weight loss and malnutrition (lack of sufficient nutrients in the body). Findings: During a review of Resident 59 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 1/27/2025 with diagnoses that included myocardial infarction (MI - heart attack), pneumonia (an infection/inflammation in the lungs), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and malignant neoplasm of right female breast (breast cancer [a disease in which some of the body ' s cells grow uncontrollably and spread to other parts of the body]).	F 806	February 28th, 2025, to identify grievances related to meal service on 3/17/2025. The Activities Director audited the last two month of Resident Council minutes to identify any grievances related to meal service on 3/17/2025. No other residents were identified having concerns related to meal service and food preferences. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Dietary Supervisor completed dietary competency evaluations of the cooks, and meal service staff on 3/13/2025 to ensure the cooks and meal service staff prepare the resident's meal tray per their documented meal ticket preferences. The Dietary Supervisor implement the use of the CAHF Meal Accuracy Report, once weekly to identify meal service accuracy concerns and report findings to the Quality Assurance Committee for improvement beginning December 2025. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Registered Dietitian will, as part of the routine kitchen audit monitor meal service to ensure meals are	

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F 806	Continued From page 164 During a review of Resident 59 ' s Minimum Data Set (MDS - resident assessment tool), dated 2/3/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required supervision / touching assistance with eating. During a review of Resident 59 ' s Dietary Profile (a written collection of information about a resident's diet), dated 1/29/2025, the Dietary Profile indicated the resident disliked fish and the resident ' s meal ticket was updated. During a review of Resident 59 ' s Order Summary Report, the Order Summary Report indicated a dietary order for consistent carbohydrate, low sodium diet, regular texture, thin liquid consistency, gluten free, dated 1/29/2025. During a review of Resident 59 ' s Care Plan (CP) regarding the resident ' s diet, initiated 1/28/2025, the CP indicated to provide food preferred if not in conflict with the treatment plan. During an interview, on 2/24/2025, at 3:34 p.m., with Resident 59, Resident 59 stated that the facility serves food items that Resident 59 has an intolerance to or dislikes. During an interview, on 2/26/2025, at 12:57 p.m., with the Dietary Supervisor (DS), the DS stated the kitchen staff is aware that Resident 59 has dietary intolerances and food dislikes, and the resident should not be served those items. The DS stated the kitchen staff ensures Resident 59 is not served food dislikes / intolerances by	F 806	prepared in accordance with the physician order and the cook has the appropriate skills and competency to prepare the resident meals. This will be done twice a month and the RD will utilize the CAHF Food & Nutrition Meal Tray Accuracy – Quality Assurance Report The IDT, including the RD will monitor resident weight monthly to identify residents with unplanned weight loss and determine the root cause of the weight loss. The Director of Activities monitors the grievances of residents monthly during resident council and will report food related concerns to the DSS following the resident council meeting for immediate correction. The Director of Social Services will monitor the grievance log for meal preparation concerns and report these concerns to the dietary services department for immediate correction. The Director of Nursing/designee will report trends identified in the dietary feedback audits to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. Allegation of Compliance Date: 3/25/2025.	

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F 806	Continued From page 165	F 806		

following the resident ' s meal ticket (a list of items that specifies the food and fluids a resident should receive) which indicates these dislikes/intolerances based on the resident ' s dietary profile.

During a concurrent observation and interview, on 2/28/2025, at 1:15 p.m., with Resident 59, Resident 59 sat at bedside eating from the lunch tray. Resident 59 stated Resident 59 dislikes fish but was served seasoned fish. Resident 59 ' s plate contained fish.

During a concurrent observation, interview, and record review, on 2/28/2025, at 1:20 p.m., with Certified Nursing Assistant (CNA) 6, Resident 59 ' s Lunch meal ticket, dated 2/28/2025, was reviewed and indicated Resident 59 does not like fish. CNA 6 stated the lunch tray is reviewed prior to being delivered to the resident and, if the meal ticket indicates the resident does not like fish, the resident should not be served fish. CNA 6 entered Resident 59 ' s room and reviewed the resident ' s meal ticket and lunch tray and stated the meal ticket indicates the resident dislikes fish, but the resident was served fish.

During an interview, on 2/28/2025, at 1:38 p.m., with the DS, the DS stated she was made aware that Resident 59 was served fish for lunch on 2/28/2025 and the resident should not have been served fish because the resident dislikes fish. The DS stated a lot of staff member ' s eyes missed that the resident had fish on her lunch plate. The DS stated when Resident 59 was served a disliked food, it can affect the resident because the resident may feel unhappy because the facility failed the resident.

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F 806	Continued From page 166 During an interview, on 2/28/2025, at 2 p.m., with the Director of Nursing (DON), the DON stated when Resident 59 was served fish and the resident disliked fish, the resident may have felt disappointed. The DON stated feeling disappointed may cause psychosocial issues affecting the resident ' s well-being and may potentially lead to unwanted weight loss in the resident. During a review of the facility policy and procedure (P&P) titled, "Food and Nutritional Services," last reviewed 12/3/2024, the P&P indicated the facility staff supports the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet. The facility provides each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The facility has an ongoing communication and coordination among and between staff within all departments to ensure the resident assessment, care plan and food and nutrition services meet each resident's daily nutritional and dietary needs and choices. Residents are offered meaningful choices in meals/diets that are nutritionally adequate and satisfying to the individual. Reasonable efforts to accommodate these choices and preferences are addressed by facility staff.	F 806	**F812** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1. The two dented cans in dry storage were removed and placed in the dented can area by the Dietary Manager on 2/24/2025 at the time of observations during the survey to avoid using it for residents as the seal of the dented cans had already been broken and can release chemical which can cause cross-contamination. 2. The Dietary Manager removed the box of open, undated graham cookie crumbs. **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** 128 residents are potentially affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;**	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812	The Dietary Services Director will re-educate the dietary staff on or before 3/19/2025 re: the facility policy and procedures: Dented cans must be removed from the food supply and placed in the dented can area to avoid using it for	

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	555904	A. BUILDING _____ B. WING _____	02/28/2025

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F 812	Continued From page 167 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: Two dented cans were found with the non-dented cans. One opened bag of crushed graham crackers did not indicate the date of when it was opened. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 128 of 150 medically compromised residents. Findings: 1. During a concurrent observation and interview on, 2/24/2025, at 8:30 a.m., with the Dietary Manager (DM), inside the dry storage room, the	F 812	residents as a dented can may have a broken seal and can release chemicals which can cause cross-contamination on or before 3/19/2025. Food products must be dated when opened to assure staff knows when to discard the product. The Registered Dietitian will complete a kitchen sanitation audit, at a minimum of quarterly to identify sanitation concerns including but not limited to presence of dented cans and opened, undated food products. A copy of the audit to the administrator and Dietary Manager for review and correction. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Dietary Manager/designee will monitor food storage, including the presence of dented cans and opened food products to ensure the open date is documented on the product weekly. The Dietary Manager/designee will report trends identified in the RD and DM audits to the QAPI/QAA Committee at least quarterly for the purpose of process improvement through root cause analysis and committee recommended interventions to ensure continued compliance with this plan of correction. **Allegation of Compliance Date:** 3/25/2025.	

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F 812	Continued From page 168 DM confirmed and stated there were two dented cans not placed in the dented can area. The DM stated it was missed during the daily inspection of dented cans by one of the kitchen staff. The DM stated it was important to separate the dented cans from non-dented cans to avoid using it for residents as the seal of the dented cans had already been broken and can release chemical which can cause cross-contamination. 2. During a concurrent observation and interview, on 2/24/2025, at 8:30 a.m., inside the dry storage room with the DM, the DM confirmed and stated an opened box of graham cookie crumbs did not indicate the date of when it was opened. The DM stated any opened items in the kitchen are labeled with the date they were opened for the staff to know until when can they use the opened items. The DM stated the kitchen staff should have labeled the graham cookie crumbs with the date it was opened so the staff would know that the graham cookie crumbs were not beyond the recommended shelf life of three (3) months for all items in the dry storage room During a review of "Food Code 2022," dated 1/18/2023, Food Code 2022 indicated, "3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of §3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest	F 812		

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F 812	Continued From page 169 presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard." During a review of the facility provided product shelf-life guide titled "A Shelf Life Guide,", undated, the product shelf-life guide indicated recommendations for pantry stored crackers after opening has a shelf life of one month. During a review of the facility ' s policy and procedure (P&P) titled, "Food Storage," last reviewed on 12/3/2024, the P&P indicated food items will be stored, thawed, and prepared in accordance with good sanitary practice. The P&P further indicated: VIII Canned Fruit Storage Guidelines C. Dented or bulging cans should be placed in a separate storage area and returned for credit. - XIII Dry Storage Guidelines G. Any opened products should be placed in storage containers with tight fitting lids. H. Label and date storage products. During a review of "Food Code 2022," dated 1/18/2023, Food Code 2022 indicated, "3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original	F 812		

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F 812	Continued From page 170 container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture ' s use-by- date if the manufacturer determined the use-by date based on food safety."	F 812	**F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)** **A. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** 1. The Infection Prevention Nurse re-educated Certified Nurse Assistant 2 re: The facility policy and procedure Oxygen Therapy, with emphasis on placing resident oxygen tubing in a bag and discarding tubing that has been on the floor o reduce the potential for respiratory infection on 2/25/25. Resident 101's oxygen tubing was discarded and new tubing was labeled, dated and replaced on 2/25/2025 at the time of observation during the survey. 2. The Infection Prevention Nurse re-educated CNA 1 on the facility policy "Hand Hygiene," with emphasis performing handwashing prior to and following providing ADL care to residents and grooming assistance; and on the facility policy and procedure Enhanced Barrier Precautions, with emphasis on donning required PPE prior to providing close contact assistance for residents who have this precaution on 2/25/2025. 3. The DSD completed a Hand Hygiene competency with CNA 1 to ensure CNA 1 has the	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		

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F 880	Continued From page 171 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880	necessary skills to complete the task prior to assisting residents with ADL care on 2/25/25 **B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action was taken;** Residents with oxygen therapy and those on Enhanced Barrier Precautions are potentially affected by the facility practice. **C. What measures will be put into place or what systematic changes the facility make to ensure that the deficient practice does not recur;** The Infection Prevention Nurse will re-educate the nursing staff on or before 3/21/2025 re: the facility policy, "Enhanced Barrier Precautions," emphasizing identifying the residents who have EBP and the use of required PPE during cares involving direct contact on or before; and the policy Oxygen Therapy with emphasis on proper storage and handling to reduce the potential for transmitting respiratory infection. The Infection Prevention Nurse/designee will in-service newly hired certified nurse assistants at the time of hire and all direct care staff annually and as needed on the facility procedure Oxygen Therapy emphasizing infection control standards and proper storage of the tubing and nasal cannula to reduce the potential for transmission of respiratory infection. The DSD will in-service newly hired	

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F 880	Continued From page 172 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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 to help prevent the development and transmission of communicable diseases and infections by failing to: 1. Ensure Certified Nursing Assistant (CNA) 2 did not place the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) from the floor onto the resident's bed for one of three sampled residents (Resident 101) reviewed under the Respiratory care area. 2. Perform hand hygiene and putting on a gown prior to performing activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily) care residents on enhanced barrier precautions (EBP - extra steps to prevent the spread of germs by wearing special protective gear, like gowns and gloves, when caring for someone who might have a highly contagious infection) for one (1) of two (2) sampled residents (Resident 65) reviewed under the Infection Control task. These deficient practices had the potential to spread infections and illnesses among residents and staff. Findings: a. During a review of Resident 101's Admission	F 880	certified nurse assistants, at the time of hire, annually and when a variance to standard is identified on the facility hand hygiene and as needed on the facility procedure Enhanced Barrier Precautions to reduce the risk of transmitting infections and increased health risk for residents. **D. How the facility plans to monitor its performance to make sure solutions are sustained;** The Infection Prevention Nurse will conduct routine walking infection prevention rounds at least twice a week including monitoring staff for use of recommended PPE when providing care to residents with EBP and the placement and storage of oxygen tubing including nasal cannula to reduce the risk of transmitting infections and increasing health risks for residents. The Director of Nursing will monitor nursing staff performance or continued compliance with EBPs through observation, IPN reports and provide re-education or progressive disciplinary action as indicated. The DON/designee will report trends identified in EBP procedures to the Quality Assurance committee during the quarterly QA&A meeting for the purpose of process improvement changes to ensure continued compliance with this plan of correction. **Allegation of Compliance Date 3/25/2025.**	

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F 880	Continued From page 173	F 880		

Record, the Admission Record indicated the facility admitted the resident on 5/15/2024 with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dependence on supplemental oxygen, and encounter for palliative care (specialized medical care for people living with a serious illness).

During a review of Resident 101's Minimum Data Set (MDS - resident assessment tool), dated 2/4/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident had no impairment of upper or lower extremities and was dependent on staff for oral and personal hygiene, toileting, bathing, and dressing. The MDS indicated the resident required oxygen therapy while a resident in the facility.

During a review of Resident 101's Order Summary Report, dated 1/29/2025, the Order Summary Report indicated an order for oxygen at 2 to four liters per minute (LPM - a unit of measurement) via NC continuously. Monitor and document oxygen saturation (O2 Sat - a measurement of the percentage (%) of oxygen in the blood) every shift. May titrate to maintain oxygen saturation greater than 91%.

During a review of Resident 101's Care Plan (CP) titled, "Refusal/Removing of oxygen therapy. Non-compliance with care. With episodes of removing oxygen tubing/devices," initiated 9/5/2024, the CP indicated to re-apply the oxygen tubing when resident is needing it.

During an observation, on 2/25/2025, at 11:10

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F 880	Continued From page 174 a.m., Resident 101 laid in bed and the NC was on the ground. During a concurrent observation and interview, on 2/25/2025, at 11:12 a.m., with CNA 2, CNA 2 entered Resident 101's room. CNA 2 picked up the NC, coiled the NC tubing, and placed the NC on Resident 101's bed next to the resident's right hand. CNA 2 stated Resident 101's NC was on the ground, and she placed the NC from the ground onto the resident's bed. CNA 2 exited Resident 101's room and the NC remained on the resident's bed within reach of the resident. During an interview, on 2/25/2025, at 11:15 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated CNA 2 notified LVN 2 that Resident 101's NC needed to be changed because it was on the ground. LVN 2 stated the NC was now on the bed. LVN 2 stated CNA 2 should not have placed the NC on the resident's bed after the NC had been on the ground. LVN 2 stated when the NC was placed on the bed it was an infection control issue. LVN 2 stated CNA 2 should have removed or left the NC on the ground until it was replaced, but she did not. During an interview, on 2/27/2025, at 12:01 p.m., with the Infection Preventionist (IP), the IP stated NCs are changed weekly and kept in a storage bag when not in use to prevent bacteria from contaminating the NC. The IP stated the NC should not be placed on a resident's bed if it was previously on the floor. The IP stated when a NC is on the floor and then placed on the bed there was a potential that bacteria from the dirty floor could transfer to the resident's bed or directly to the resident if they put on the NC.	F 880		

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F 880	Continued From page 175 During an interview, on 2/28/2025, at 11 a.m., with the Director of Nursing (DON), the DON stated CNA 2 should not have placed Resident 101's NC from the floor to the bed. The DON stated CNA 2 should have left the NC on the floor and called the nurse to replace it. The DON stated the floor is dirty and could potentially cause cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) resulting in an infection in Resident 101. The DON stated the facility's policy and procedure (P&P) was not followed when CNA 2 placed Resident 101's NC on the bed after the NC was on the floor. During a review of the facility's P&P titled, "Infection Prevention and Control Program," last reviewed 12/3/2024, the P&P indicated the purpose of the policy was to ensure the facility establishes and maintains an infection control program designed to provide a safe sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with federal and state requirements. Infection prevention and control program standards apply to all facility employees who provide care and services to residents. During a review of the facility P&P titled, "Oxygen Therapy," last reviewed 12/3/2024, the P&P indicated the purpose was to provide guidelines for the administration of oxygen. The NC is a tube that is placed approximately one-half inch into the resident's nose. All NCs used to deliver oxygen will be changed weekly and when visibly soiled and will be stored in a plastic bag at the resident's bedside to protect equipment from dust and dirt when not in use.	F 880		

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F 880	Continued From page 176 b. During a review of Resident 65's Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/8/2021 and readmitted on 1/10/2025 with diagnoses including type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), calculus of gallbladder (also known as gallstones, are hardened deposits of fats and bile [a fluid that is made and released by the liver and stored in the gallbladder] which aids with digestion) calcium salts that form in the [gallbladder - a small, pear-shaped organ that stores and releases bile to help digest food]), and generalized muscle weakness. During a review of Resident 65's History and Physical (H&P), dated 1/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's MDS, dated 1/17/2025, the MDS indicated Resident 65 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required partial/moderate assistance with toileting hygiene, bathing, and lower body dressing; substantial/maximal assistance from staff with all other ADLs. During a review of Resident 65's Order Summary Report, dated 1/16/2025, the Order Summary Report indicated a physician's order for EBP due to medical device right upper abdomen (RUA) biliary drain (a thin, flexible tube inserted into the bile duct to help drain excess bile if the duct is blocked, allowing the bile to flow out into a collection bag outside the body).	F 880		

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F 880	Continued From page 177 During a review of Resident 65's CP on EBP related to medical device (RUA biliary drain), initiated on 1/16/2025 and last revised on 1/24/2025, the CP indicated health teaching to resident, family members, and staff about importance of EBP including proper hand hygiene and wearing of personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) during high-contact resident activities as one of the interventions to minimize risk and complications of infection. During an observation, on 2/24/2025, at 10:21 a.m., inside Resident 65's room, CNA 1 put on gloves without performing hand hygiene and grabbed three (3) wash cloths inside a plastic bag on top of Resident 65's bed. CNA 1 went to the bathroom, wet the washcloths, and started wiping Resident 65's eyes from the inside corner to outer corner with one wash cloth, placed the 3 washcloths on top of the overbed table that was not cleaned or sanitized, and left the room without removing her gloves. During a concurrent observation and interview, on 2/24/2025, at 10:27 a.m., inside Resident 65's room, with CNA 1, CNA 1 put on gloves without performing hand hygiene and started providing ADL care to Resident 65 using the washcloths placed on top of the overbed table. CNA 1 stated she did not know Resident 65 was on EBP, and she did not pay attention to the EBP sign taped at the doorway. CNA 1 was unable to answer why Resident 65 was on EBP. CNA 1 stated staff are supposed to wear PPEs while providing care to residents who are on EBP to prevent spread of infection among residents. CNA 1 stated she	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 178 should have paid attention to the EBP sign at the door, performed hand hygiene, and put on the proper PPE prior to providing ADL care to Resident 65 to prevent spread of infection to the other residents. During a concurrent observation and interview, on 2/24/2025, at 10:30 a.m., inside Resident 65's room, with LVN 9, LVN 9 stated staff are supposed to perform hand hygiene and put on the proper PPEs prior to performing high contact activities to residents on EBP to prevent spread of infection among residents and staff. LVN 9 stated Resident 65 was on EBP due to presence of RUA biliary drain. LVN 9 told CNA 1 that she should have put on a gown while providing care to Resident 65. LVN 9 stated CNA 1 should have performed proper hand hygiene and put on the proper PPEs prior to providing care to Resident 65. During an interview, on 2/27/2025, at 12:05 p.m., with the IP, the IP stated residents on EBP are identified by blue colored sign at the door indicating a number 1 for the resident in bed 1 and number 2 for the resident in bed 2. The IP stated staff must perform the proper hand hygiene using a hand sanitizer or washing their hands and put on the proper PPEs prior to performing high contact activities to residents on EBP such as the presence of any tubes or catheters, wounds, changing linens, providing ADL care. The IP stated CNA 1 should have performed the proper hand hygiene and put on the proper PPEs prior to providing care to Resident 65 to prevent or stop the spread of infection or cross contamination between the residents and staff.	F 880		

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F 880	Continued From page 179 During an interview, on 2/28/2025, at 1:00 p.m., with the DON, the DON stated that all staff were supposed to perform the proper hand hygiene and put on the proper PPEs prior to performing high contact activities such as providing ADL care to any resident on EBP. The DON stated CNA 1 should have performed proper hand hygiene using the hand sanitizer or washing her hands and put on the proper PPEs prior to providing ADL care to Resident 65 as she was on EBP due to presence of RUA biliary drain to prevent cross contamination and spread of infection among residents and staff. During a review of the facility's P&P titled, "Enhanced Barrier Precautions," last reviewed on 12/3/2024, the P&P indicated the facility will utilize guidance to determine the appropriate PPE to be utilized during the care of residents to minimize the risk of infection or spread of infection. The P&P further indicated: - I. 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 of MDROs to staff hands and clothing. - II. EBP are indicated for residents with any of the following: B. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multidrug resistant organism (MDRO). - IV. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. During a review of the facility's P&P titled, "Infection Prevention and Control Program," last reviewed on 12/3/2024, the P&P indicated the	F 880		

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F 880	Continued From page 180 facility establishes and maintains an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements.	F 880		