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	555791	A. BUILDING _____ B. WING _____	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS HEALTHCARE CENTER	17650 DEVONSHIRE STREET NORTHRIDGE, CA 91325

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Recertification Survey. The Recertification survey was conducted on 6/5/2024. Representing the Department of Public Health: Surveyor ID No. 43418, Health Facilities Evaluator Nurse Surveyor ID No. 43988, Health Facilities Evaluator Nurse Surveyor ID No. 44244, Health Facilities Evaluator Nurse Surveyor ID No. 44376, Health Facilities Evaluator Nurse Surveyor ID No. 49947, Health Facilities Evaluator Nurse Facility Census: 45 Resident Sample Size: 16 Highest Severity and Scope: E One deficiency was identified for the Complaint Number: CA00902453 (Refer to F880).	F 000	Preparation and/or execution of this plan of correction does not constitute admission by the provider or the truth of the facts set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the California Health and Safety Code Section 1280 and Code of Federal Regulations.	6/28/24
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550	F550 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: A privacy cover was provided for Resident 249's urinary bag by the licensed nurse (LN) on 06/04/2024. How the facility identified other residents having the potential to be affected by the deficient practice: Residents with urinary bags were reviewed on 6/4/24 by the LN to ensure they were covered for privacy and dignity. No other residents were identified to be affected by the deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith Vogel NHA	Administrator	6/28/24

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 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of their individuality for one of two sampled residents (Resident 249) when Resident 249's urinary catheter bag (device used to collect urine drained from the bladder via a urinary catheter [a tube	F 550	Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: On 6/21/24 and 6/22/24 the LNs and CNAs were in-serviced by the Director of Staff Development (DSD) regarding the facility policy and importance of placing a urinary bag with cover in order to promote privacy and dignity for residents with a urinary bag. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The DSD or designee will monitor residents with urinary bags weekly for 3 months to ensure the bags are covered to promote privacy and dignity for residents. Any issues identified will be corrected. The findings or trends will be reported by the Administrator or Designee to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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inserted into the bladder through the urethra (duct that lets urine leave the bladder and body) to allow urine to drain]) was not covered with a privacy bag (also known as a dignity bag - device used to cover the contents or a urinary catheter bag).

This deficient practice had the potential to negatively affect the resident's psychosocial wellbeing and loss of dignity.

Findings:

A review of Resident 249's Admission Record indicated the facility admitted the resident on 5/31/2024, with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest task), acute kidney failure (abrupt decrease in kidney function), and retention of urine (a condition in which urine cannot empty from the bladder).

A review of Resident 249's History and Physical (H&P), dated 6/3/2024, indicated the resident can make needs known but cannot make medical decisions.

A review of Resident 249's Order Summary Report, dated 5/31/2024, indicated an order for indwelling foley catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) 16F (catheter size)/10 milliliters (ml, a unit of volume).

During a concurrent observation and interview on 6/4/2024, at 9:18 a.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 249's room, the resident did not have a privacy cover on his

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F 550	Continued From page 3 urinary catheter bag. CNA 3 stated they should have provided a privacy cover for the resident's urinary catheter bag to promote the resident's dignity. During an interview on 6/5/2024, at 10:30 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 249's urinary catheter bag should have a privacy cover to provide dignity and respect to the resident. A review of the facility's recent policy and procedure titled, "Dignity," last reviewed on 1/15/2024, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents, for example: a. helping the resident to keep urinary catheter bags covered.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578	F578 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident 34 discharged from the facility 06/22/2024. How the facility identified other residents having the potential to be affected by the deficient practice: Current residents' clinical records were reviewed by the Social Services Director (SSD) on 6/17/24 for complete and accurate advance directive acknowledgment forms. No other issues regarding advance directives were identified. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur:	

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F 578	Continued From page 4 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to offer the resident or their resident representative assistance with formulating an Advance Directive (AD - a legal document telling the doctor one's wishes about their healthcare in the event they cannot make the decision for themselves) upon admission to one out of two sampled residents (Resident 34) investigated during review of advance directive care area.	F 578	The SSD was in-serviced by the Administrator or Designee on 6/17/24 regarding the facility policy and the timely and accurate completion of the resident advance directive acknowledgment form. The licensed nurses were in-serviced by the DON on 6/26/24 regarding the facility policy and the timely and accurate completion of the resident advance directive acknowledgment form. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The SSD or designee will audit weekly for 3 months for timely, accurate and complete resident advance directive acknowledgment form upon admission. Any issues identified will be corrected. The SSD will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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This deficient practice violated the resident and/or their representative the right to be fully informed of the option to formulate an AD and had the potential to delay emergency treatment or the potential to force emergency, life-sustaining procedures against the resident's personal preferences.

Findings:

A review of Resident 34's Admission Record indicated the facility admitted the resident on 3/5/2024 with diagnoses including type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy with hyperglycemia (a condition that happens when there is too much sugar in the blood).

A review of Resident 34's History and Physical (H&P) dated 3/6/2024, indicated the resident was able to make her needs known but did not have the capacity to make decisions.

A review of Resident 34's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/8/2024 indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required set -up or clean up assistance with eating and oral hygiene; partial/moderate assistance with personal hygiene and bed mobility; totally dependent on 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 34's Multidisciplinary Care Conference Form and Social Services Evaluation on 6/4/2024 at 12:05 p.m., the form

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and the evaluation did not indicate the AD was discussed with the resident or the resident representative.

During a concurrent interview and record review on 6/4/2024 at 3:44 p.m., with the Social Services Director (SSD), reviewed Resident 34's Multidisciplinary Care Conference Form dated 3/13/2024 and Social Services Evaluation dated 3/13/2024. The SSD verified there was no documented evidence AD was discussed with the resident or resident representative during the care conference meeting. The SSD stated it was important to discuss the AD with the residents and/or their representative so that the healthcare team would be aware of the residents' wishes concerning medical care.

During an interview on 6/5/2024 at 4:00 p.m., the Assistant Director of Nursing (DON) stated the SSD is responsible for asking the resident and/or representative during admission about the existence of an AD. The ADON stated assistance with the formulation of AD should have been offered to the resident and/or representative because they (resident and their representative) have the right to make decisions concerning medical care and have their decisions respected and honored.

A review of the facility's policy ad procedure titled, "Advance Directive," last reviewed 1/15/2024, indicated AD are honored in accordance with the state law and facility policy. The policy indicated the following:
Determining the existence of AD:
- Prior to or upon admission, the SSD or designee inquires about the existence of any written AD.

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F 578	Continued From page 7 - The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an AD if he or she chooses to do so. - Written information is provided in a manner that is easily understood by the resident or representative.	F 578		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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	F 656	F656 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. A care plan was developed by the Licensed Nurse (LN) for the use of buspirone for Resident 29 on 6/5/24. 2. Care plans for the use of anticoagulant medications were developed by the LN for Residents 5 on 6/20/24 and anticoagulant heparin medication was discontinued on 5/6/24 for resident 11. Resident 196 discharged from the facility 06/10/2024. 3. A care plan for the use side rails was developed by the LN for Residents 11 on 6/21/24. Resident 20 discharged from the facility 06/11/2024. 4. A care plan for urinary catheter was developed by the LN for Resident 249 on 6/9/24. Resident 40 discharged from the facility 06/20/2024.	

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F 656	Continued From page 8 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 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 (CP, a plan for individual's specific health needs and desired health outcomes) by: 1. Failing to ensure a CP for the use of buspirone (an anxiolytic, a medication used to treat feelings of fear, dread, uneasiness, or muscle tightness, that may occur as a reaction to stress) was developed and implemented for one of two sampled residents (Resident 29) investigated during review of psychotropic (medications that affect the mind, emotions, and behavior) / opioid (strong medication to treat pain) medication side effects care area. 2. Failing to ensure CPs for the use of anticoagulants (a class of medications used to prevent blood clots [clumps that occurs when	F 656	How the facility identified other residents having the potential to be affected by the deficient practice: Current residents' clinical records were reviewed on 6/21/24 by the LN for the development of a comprehensive person-centered, specific and individualized care plan as it related to the use of psychotropic and anticoagulant medications; and the use of side rails and urinary catheters. No other issues with the development of care plans for those residents were identified. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: MDS and Nursing staff were in-serviced by the Corporate Nurse Consultant or designee on 06/20/2024 and 6/26/24 regarding the timely completion of a comprehensive person-centered, specific and individualized care plan, especially care plans for the use of psychotropic and anticoagulant medications; and the use of side rails and urinary catheters. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system:	

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F 656	Continued From page 9 blood hardens from a liquid to a solid]) were developed and implemented for one of one sampled residents (Resident 196) reviewed under the care area anticoagulants and two of five sampled residents (Resident 5 and 11) investigated during review of area unnecessary medications. 3. Failing to ensure a CP for the use of side rails (a barrier attached to the side of a bed) was developed and implemented for two out of two sampled residents (Residents 11 and 20) investigated during review of accidents care area 4. Failing to ensure a CP for urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag) was developed and implemented for two of two sampled residents (Resident 249 and Resident 40) investigated during review of urinary catheters care area. These deficient practices placed the residents at risk for not receiving the necessary services and treatment to meet their medical, physical, mental, and psychosocial needs. Findings: 1. A review of Resident 29's Admission Record indicated the facility admitted the resident 10/14/2021 and readmitted the resident on 4/17/2024 with diagnoses that included dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), lack of coordination, and presence of artificial hip joint. A review of Resident 29's Minimum Data Set	F 656	Medical Records or designee will audit for both new admissions weekly for 3 months and then on-going for the completion of comprehensive person-centered care plans, especially care plans for the use of psychotropic and anticoagulant medications; and the use of side rails and urinary catheters. Any issues identified will be corrected. The Medical Records Director or designee will monitor for compliance and report any findings/trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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(MDS - a standardized assessment and care screening tool) dated 4/20/2024, indicated the resident was sometimes able to understand others and sometimes was able to make himself understood. The MDS further indicated the resident was dependent on staff for bathing, dressing, and toileting.

A review of Resident 29's physician orders indicated an order for buspirone HCL five milligrams (mg, a unit of measurement) oral tablet, give five mg by mouth two times a day for anxiety manifested by restlessness leading to shortness of breath, dated 4/28/2024.

During an interview and record review on 6/4/2024 at 4:42 p.m., the Assistant Director of Nursing (ADON) reviewed Resident 29's physician orders. The ADON stated Resident 29 had a physician order for buspirone, a psychotropic medication, due to the resident's behavior of restlessness leading to shortness of breath. The ADON stated psychotropic drugs have side effects and should not be given if they are not needed.

During a concurrent interview and record review on 6/5/2024 at 11:52 a.m., the Minimum Data Set Coordinator (MDSC) reviewed Resident 29's physician orders and care plans. The MDSC stated CPs include interventions based on identified resident problems and goals that are re-evaluated to ensure the facility is providing the proper care to residents. The MDSC stated CPs are important for the staff to be aware of the specific needs of the residents and to identify specific medications that affect the residents' health and safety. The MDSC stated Resident 29 was receiving buspirone, a psychotropic

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medication. The MDSC stated all psychotropic medication should have a specific CP. The MDSC stated care plans are important for psychotropic medications to ensure resident behaviors are monitored and the medication is evaluated for effectiveness. The MDSC stated if there was no CP for a psychotropic medication it may result in unnecessary medications being administered because of the lack of evaluating the usage of the medication. The MDSC stated when psychotropic medications are given unnecessarily it could possibly affect the resident's health and safety due to altered cognition leading to the resident possibly falling.

During a concurrent interview and record review on 6/5/2024 at 4:47 p.m., the ADON reviewed the facility policy and procedure regarding CPs. The ADON stated residents should have a resident specific CP for psychotropic medications due to the need for medication re-evaluation by the physician with the goal of lowering the medication dose. The ADON stated the CP would indicate that the physician is aware, consent was obtained for the medication, and behaviors were monitored. The ADON stated if a resident was on a psychotropic medication without a CP it could affect the resident's condition because the resident's progress towards achieving the CP goals needs to be reviewed to ensure the resident is being treated properly. The ADON stated the facility policy and procedure was not followed because the resident did not have a CP for buspirone.

A review of the facility provided policy and procedure titled, "Care Planning - Interdisciplinary Team," last reviewed 1/15/2024, indicated the interdisciplinary team is responsible for the

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development of resident care plans. Resident care plans are developed according to the timeframes and criteria established.

A review of the facility provided policy and procedure titled, "Care Plans, Comprehensive Person-Centered," last reviewed 1/15/2024, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive care plan describes the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan reflects currently recognized standards of practice for problem areas and conditions. Assessments of resident's are ongoing and care plans are revised as information about the resident and the residents' conditions change.

2. A review of Resident 196's Admission Record indicated the facility admitted the resident on 4/23/2024 with diagnoses that included fracture (broken bone) of the sacrum (region at the bottom of the spine), hypertension (high blood pressure), and atrial fibrillation (afib, an irregular and often very rapid heart rhythm that can lead to blood clots in the heart).

A review of Resident 196's MDS dated 4/26/2024, indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident required partial assistance with oral

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hygiene and upper body dressing, maximum assistance with lower body dressing and putting on footwear, and was dependent on staff for bathing and toileting.

A review of Resident 196's physician orders indicated an order for apixaban (an anticoagulant medication), oral tablet 2.5 mg, give 2.5 mg by mouth two times a day for blood thinner. Dated 4/23/2024.

During a concurrent interview and record review on 6/5/2024 at 11:52 a.m., the MDSC reviewed Resident 196's physician orders and care plans. The MDSC stated CPs include interventions based on identified resident problems and goals that are re-evaluated to ensure the facility is providing the proper care to residents. The MDSC stated CPs are important for the staff to be aware of the specific needs of the residents and to identify specific medications that affect the residents' health and safety. The MDSC stated anticoagulant care plans are used to identify a resident's risk for bleeding with interventions to monitor for side effects. The MDSC stated Resident 196 had an order for apixaban but did not have an anticoagulant CP for risk for bleeding. The MDSC stated not having the CP could potentially result in staff failing to identify the risk of the medication and not having a plan of care to rely on to provide the proper interventions. The MDSC stated the resident would be at risk for health problems like bleeding and bruising without the anticoagulant CP.

During a concurrent interview and record review on 6/5/2024 at 4:47 p.m., the ADON reviewed the facility policy and procedure regarding care plans. The ADON stated the purpose of the care plan

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was to know the resident specific goals and interventions for the plan of care. The ADON stated without a CP, the staff would not be aware of the resident's specific situations related to their diagnoses. The ADON stated the CP is a guide for the staff in providing resident care. The ADON stated Resident 196 did not have a CP for the use of apixaban. The ADON stated the importance of the CP was to monitor for side effect of bleeding that could affect the total health of the resident. The ADON stated the facility policy was not followed because there was not a CP for Resident 196's use of apixaban.

A review of the facility provided policy and procedure titled, "Care Planning - Interdisciplinary Team," last reviewed 1/15/2024, indicated the interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established.

A review of the facility provided policy and procedure titled, "Care Plans, Comprehensive Person-Centered," last reviewed 1/15/2024, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive care plan describes the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan reflects currently recognized standards of practice for problem areas and conditions. Assessments of

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resident's are ongoing and care plans are revised as information about the resident and the residents' conditions change.

3. A review of Resident 5's Admission Record indicated the facility admitted Resident 5 on 1/25/2021 with diagnoses including, but not limited to, type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and transient cerebral ischemic attack (a brief episode of neurological [relating to the brain] dysfunction resulting from an interruption in the blood supply to the brain or the eye).

A review of Resident 5's MDS, dated 3/13/2024, indicated Resident 5 had moderate cognitive impairment (difficulty understanding and making decisions), required supervision with eating, and required maximal assistance or was dependent on facility staff for other activities of daily living, including hygiene, toileting, and surface to surface transfers.

A review of Resident 5's Order Summary Report, dated 10/25/2023, indicated Resident 5 was ordered rivaroxaban (also known as Xarelto, medication that thins the blood) oral tablet 2.5 mg, give one tablet by mouth two times a day for cerebrovascular accident (also known as a stroke, damage to the brain from interruption of its blood supply) prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease).

During a concurrent interview and record review with the ADON, on 6/5/2024, at 4:50 p.m., Resident 5's medical record was reviewed and the ADON confirmed Resident 5 was ordered

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Xarelto for stroke prophylaxis on 10/25/2023. The ADON confirmed Resident 5 did not have a care plan for use of Xarelto and stated it is important to have a care plan for Xarelto use to check for side effects of the medications, which include bleeding and bruising. The ADON stated if the resident is not checked for side effects, it can affect the health of the resident and the resident can potentially experience different complications from the medications. The ADON stated the purpose of care plans is to help nurses determine the goals for the resident and to determine the kind of interventions to reach the goals of the resident. The ADON further stated without a care plan, the staff would not be aware of what interventions to implement, and it is a good practice to have the plan of care in writing to guide the staff.

A review of the facility's policy and procedure (P&P) titled, "Care Planning - Interdisciplinary Team," last reviewed 1/15/2024, indicated the interdisciplinary team is responsible for development of resident care plans and are based on resident assessments.

A review of the facility's P&P titled, "Care Plans, Comprehensive Person-Centered," last reviewed 1/15/2024, indicated the comprehensive, person centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and reflects the currently recognized standards of practice for problem areas and conditions.

4.a. A review of Resident 11's Admission Record indicated the facility admitted the resident on

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4/5/2024, with diagnoses including age-related osteoporosis (bone loss occurs with aging in all adults), dementia, and gastritis (inflammation of the lining of the stomach).

A review of Resident 11's History and Physical (H&P), dated 4/8/2024, indicated the resident was on heparin every 8 hours for deep vein thrombosis (DVT, the formation of one or more blood clots in one of the body's large veins) prophylaxis (ppx, preventive). The H&P indicated the resident had the capacity to make needs known but cannot make medical decisions.

A review of Resident 11's MDS, dated 4/8/2024, indicated the resident had the ability to make self-understood and understand others. The resident required substantial to maximal assistance on mobility and activities of daily living (ADLs) and was on a high-risk drug class anticoagulant and antiplatelet medications (medications that prevent blood clots from forming).

A review of Physician's Order, dated 5/6/2024, indicated an order for heparin sodium (Porcine, an anticoagulant medication) injection solution 5000 unit (an amount approximately equivalent to 0.002 milligrams [mg, a unit of weight] of pure heparin)/ milliliters (ml, a unit of volume). Inject 1 cubic centimeter (cc, a unit of volume) subcutaneously (beneath, or under, all the layers of the skin) every 8 hours for DVT PPX. Rotate (a method to ensure repeated injections are not administered in the same area) sites of injection.

During an observation on 6/4/2024, at 8:48 a.m., inside Resident 11's room, observed the resident's bed with half (½) right side rail up.

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During a concurrent interview and record review on 6/5/2024, at 10:09 a.m., with the ADON, reviewed Resident 11's Order Summary Report and care plans. The ADON stated there was no documented care plan for the use of side rail and anticoagulant medication on the resident's medical record. The ADON stated it was important to have care plans for side rails and heparin use to communicate the interventions required to properly care for the resident. The ADON stated having a care plan for side rail use can prevent unusual occurrences such as entrapment (an event in which a patient is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or hospital bed frame). The ADON stated having a care plan for anticoagulant can help prevent the resident from experiencing complications such as bleeding and bruising.

A review of the facility's recent policy and procedure titled, "Care Planning- Interdisciplinary Team," last reviewed on 1/15/2024, indicated the interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established by 438.21.

A review of the facility's recent policy and procedure titled, "Care Plans, Comprehensive Person-Centered," last reviewed on 1/15/2024, indicated the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.

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4.b A review of Resident 20's Admission Record indicated the facility admitted the resident on 3/6/2024, with diagnoses including dependence on other enabling machines and devices, lack of coordination, and muscle weakness.

A review of Resident 20's H&P, dated 4/18/2024, indicated the resident had physical debility, muscle weakness, and physical deconditioning. The H&P indicated the resident can make needs known but cannot make medical decisions.

A review of Resident 20's MDS, dated 3/9/2024, indicated the resident usually had the ability to make self-understood and understand others. The MDS indicated the resident substantial to partial assistance on mobility and activities of daily living (ADLs).

During an observation on 6/4/2024, at 8:33 a.m., inside Resident 20's room, observed the resident's bed with half (½) side rail up.

During a concurrent interview and record review on 6/5/2024, at 10:09 a.m., with the ADON, reviewed Resident 20's Order Summary Report and the care plans. The ADON stated there was no documented care plan on the use of the side rails in the resident's medical record. The ADON stated it was important to have a care plan for side rail use to communicate the interventions required to properly care for the resident. The ADON stated having a care plan for side rail use can prevent unusual occurrences such as entrapment.

A review of the facility's recent policy and procedure titled, "Care Planning- Interdisciplinary Team," last reviewed on 1/15/2024, indicated the

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interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established by 438.21.

A review of the facility's recent policy and procedure titled, "Care Plans, Comprehensive Person-Centered," last reviewed on 1/15/2024, indicated the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.

5. A review of Resident 249's Admission Record indicated the facility admitted the resident on 5/31/2024, with diagnoses including acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from the blood) and retention of urine (a condition in which the body is unable to empty all the urine from the bladder).

A review of Resident 249's H&P, dated 6/3/2024, indicated the resident can make needs known but cannot make medical decisions.

A review of Resident 249's Order Summary Report, dated 5/31/2024, indicated an order for indwelling urinary catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) 16 french (F, catheter size)/10 ml.

During an interview and record review on 6/5/2024, at 10:30 a.m., with the ADON, reviewed Resident 249's Order Summary Report and care plans. The ADON stated there was no

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documented care plan for urinary catheter in the resident's medical record. The ADON stated it was important to have a care plan for side rail use to communicate the interventions required to properly care for the resident. The ADON having a care plan on indwelling urinary catheter can help guide the healthcare team implement interventions that could help prevent urinary tract infections associated with the use of urinary catheters.

A review of the facility's policy and procedure (P&P) titled, "Care Planning - Interdisciplinary Team," last reviewed 1/15/2024, indicated the interdisciplinary team is responsible for development of resident care plans and are based on resident assessments.

A review of the facility's P&P titled, "Care Plans, Comprehensive Person-Centered," last reviewed 1/15/2024, indicated the comprehensive, person centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and reflects the currently recognized standards of practice for problem areas and conditions.

6. A review of Resident 40's Admission Record indicated the facility admitted on 5/9/2024, with diagnoses that included, but not limited to benign prostatic hyperplasia (a condition that enlarges the small reproductive organ found in males that surrounds the tube that empties the bladder), UTI, and retention of urine.

A review of Resident 40's History and Physical (H&P), dated 5/12/2024, it indicated the resident

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was readmitted to facility on 5/9/2024 from a general acute care hospital (GACH) due to a UTI and indwelling catheter replacement. The H&P indicated the resident had the capacity to understand and make decisions.

A review of Resident 40's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/16/2024, it indicated Resident 40 had an indwelling catheter and mild cognitive impairment. The MDS also indicated Resident 40 required moderate assistance with bed mobility, dressing, and personal hygiene.

A review of Resident 40's Order Summary Report printed on 6/5/2024, it indicated on 5/10/2024, Resident 40's physician ordered an indwelling catheter 18 French (size of the indwelling catheter) connected to drainage bag for urinary retention.

A review of Resident 40's Care Plan on 6/4/2024 did not indicate a care plan for Resident 40's indwelling catheter.

During a concurrent interview and record review on 6/4/2024 at 12:30 p.m. with Assistant Director of Nursing (ADON), reviewed Resident 40's care plan with the ADON. ADON confirmed there was not an indwelling catheter care plan for the resident. ADON stated without the care plan, the resident might not receive the person-centered indwelling catheter care to prevent another UTI and hospitalization. ADON further stated without the care plan staff might not recognize the signs and symptoms of a UTI, including confusion and falls.

A review of the facility's Policies and Procedures

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F 656	Continued From page 23 (P&P) titled "Care Planning - Interdisciplinary (people from different occupation areas working together) Team," revised on 1/15/2024, indicated, "The interdisciplinary team is responsible for the development of resident care plans. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team."	F 656		
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 by: Based on observation, interview, and record review, the facility failed to ensure licensed nurses provide care in accordance with professional standards to three (3) of five sampled residents (Resident 34, 11, and 5) investigated during review of insulin use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (SQ = beneath the skin) insulin (a hormone that lowers the level of sugar in the blood) administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat), bleeding, and or bruising. Cross Reference F760	F 658	F658 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. Resident 5 was assessed for any adverse effects of subcutaneous (SC) insulin administration and the physician notified by the Licensed Nurse (LN) on 6/6/24. 2. Resident 11 was assessed for any adverse effects of SC heparin administration and the physician notified by the LN on 6/6/24. 3. Resident 34 discharged from the facility 06/22/2024. 4. The Director of Nursing (DON) in-serviced the LNs on 6/15/24 and 6/18/24 regarding the policy for administering SC injections insulin and heparin and the importance of rotating the SC administration sites in order to prevent any adverse effects.	

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F 658	Continued From page 24 Findings: a. A review of Resident 34's Admission Record indicated the facility admitted the resident on 3/5/2024 with diagnoses including type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy with hyperglycemia (a condition that happens when there's too much sugar in the blood). A review of Resident 34's History and Physical (H&P) dated 3/6/2024, indicated the resident was able to make her needs known but did not have the capacity to make decisions. A review of Resident 34's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/8/2024 indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required set -up or clean up assistance with eating and oral hygiene; partial/moderate assistance with personal hygiene and bed mobility; totally dependent on staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 34 received insulin injections. A review of Resident 34's Order Summary Report indicated the following orders: - Humalog kwik-pen SQ solution pen injector 100 unit per milliliter (unit/ml - a unit of measurement (insulin lispro - a short-acting, manmade version of human insulin) inject as per sliding scale: if 71-149 = 0, less than 70 = give orange juice or glucagon call physician; 150-200 = 2; 201-250 = 4; 251-300 = 7; 301-350 = 7; 301-350 = 10; 351-400 = 12, more than 400 give 14,	F 658	How the facility identified other residents having the potential to be affected by the deficient practice: Current residents that were prescribed SC insulin and heparin were reviewed by the LN on 6/6/24. No other residents were affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The Director of Nursing (DON) in-serviced the LNs on 6/15/24 and 6/18/24 regarding the policy for administering SC insulin and heparin; and the importance of rotating the SC administration sites in order to prevent any adverse effects. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system:	

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	555791	A. BUILDING _____ B. WING _____	06/05/2024

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F 658	Continued From page 25 call physician, SQ before meals and at bedtime for diabetes. - insulin glargine solution (a form of hormone insulin made in the laboratory used to control the amount of sugar in the blood of patients with diabetes) 100 unit/ml inject 14 units SQ one time a day for diabetes. - Insulin glargine solution 100 unit/ml inject seven (7) unit SQ at bedtime for diabetes. A review of Resident 34's care plan on risk for hypoglycemia (low blood sugar) and hyperglycemia related to diabetes initiated on 3/13/2024 indicated to administer prescribed insulin as ordered. A review of Resident 34's Location of Administration Report for insulin from 5/2024 to 6/2024 indicated the following: -Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML was administered on: 05/11/24 06:30 05/11/24 06:24 subcutaneously Abdomen - Right Lower Quadrant - RLQ 05/11/24 11:30 05/11/24 11:57 subcutaneously Abdomen - RLQ 05/16/24 06:30 05/16/24 06:50 subcutaneously Abdomen - RLQ 05/16/24 06:30 05/16/24 06:50 subcutaneously Abdomen - RLQ 05/16/24 11:30 05/16/24 11:20 subcutaneously Abdomen - RLQ 05/18/24 06:30 05/18/24 06:39 subcutaneously Abdomen - RLQ 05/18/24 11:30 05/18/24 11:05 subcutaneously Abdomen - RLQ 05/22/24 06:30 05/22/24 07:14 subcutaneously Abdomen - Left Upper Quadrant - LUQ 05/22/24 11:30 05/22/24 11:50 subcutaneously	F 658	The Medical Records Director or designee will audit weekly for 3 months the rotation of SC insulin and heparin administration sites on the medication administration record and report the findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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F 658	Continued From page 26 Abdomen - LUQ 05/28/24 06:30 05/28/24 06:47 subcutaneously Abdomen - RLQ 05/28/24 11:30 05/28/24 12:53 subcutaneously Abdomen - RLQ 06/02/24 06:30 06/02/24 06:25 subcutaneously Abdomen - Right Upper Quadrant (Abdomen - RUQ) 06/02/24 11:30 06/02/24 12:04 subcutaneously Abdomen - RUQ 06/04/24 11:30 06/04/24 11:29 subcutaneously Abdomen - Left Lower Quadrant (LLQ) 06/05/24 11:30 06/05/24 12:15 subcutaneously Abdomen - LLQ -Insulin Glargine Solution 100 UNIT/ML was administered on: 05/07/24 21:00 05/07/24 21:21 subcutaneously Abdomen - RLQ 05/11/24 21:00 05/11/24 22:50 subcutaneously Abdomen - RLQ 05/22/24 21:00 05/22/24 21:25 subcutaneously Abdomen - RLQ During a concurrent interview and record review on 6/05/24 at 4:30 p.m., reviewed Resident 34's Humalog and Insulin Glargine Location of Administration Sites in the Medication Administration Record (MAR) for the month of 5/2024 and 6/2024 with the Assistant Director of Nursing (ADON). The ADON verified the administration sites for the Humalog and Insulin Glargine were not rotated. The ADON stated the administration sites should have been rotated to prevent bruising, bleeding, and irritation on the site which may lead to poor absorption of the medication and the resident not getting the required amount of insulin.	F 658		

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A review of the insulin glargine patient package insert provided by the facility, dated 2023, indicated to change (rotate) injection sites within the area chosen with each dose to reduce the risk of getting lipodystrophy and localized cutaneous amyloidosis (skin with lumps). The package insert further indicated to not use the exact same spot for each injection, not inject where the skin has pits, is thickened, or has lumps, where the skin in tender, bruised, scaly or hard, scars, or damaged skin.

A review of the Humalog manufacturer's guidelines provided by the facility last revised 8/2023, indicated to rotate the injection site within the same to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

b. A review of Resident 11's Admission Record indicated the facility admitted the resident on 4/5/2024, with diagnoses including atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (occurs when the heart muscle does not pump blood as well as it should), and gastritis (inflammation of the lining of the stomach).

A review of Resident 11's History and Physical (H&P), dated 4/8/2024, indicated the resident was receiving heparin every 8 hours for deep vein thrombosis (DVT, a blood clot that develops within a deep vein in the body, usually in the leg) prophylaxis (PPX, preventive). The H&P also indicated the resident had the capacity to make needs known but unable to make medical decisions.

A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care

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screening tool), dated 4/8/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had moderately impaired cognition (a range of mental processes relating to the acquisition, storage, manipulation, and retrieval of information) and was on a high drug class medications anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the hear) and antiplatelet drugs (a group of medicines that stop blood cells [called platelets] from sticking together and forming a blood clot).

A review of Resident 11's Order Summary Report, on 5/6/2024, indicated an order for heparin sodium (Porcine) injection solution 500 unit (an amount approximately equivalent to 0.002 mg of pure heparin)/milliliters (ml, a unit of volume). Inject 1 cubic centimeter (cc, a unit of volume) subcutaneously every 8 hours for DVT PPX. Rotate sites of injection.

A review of Resident 11's Location of Administration Report for the months of 4/2024 to 5/20204, indicated heparin was administered on:
4/9/24 at 6:34 a.m. on the Abdomen - Right Lower Quadrant (RLQ)
4/9/24 at 1:45 p.m. on the Abdomen - RLQ
4/9/24 at 9:28 p.m. on the Abdomen - RLQ
4/10/24 at 5:25 a.m. on the Abdomen - RLQ
4/10/24 at 2:08 p.m. on the Abdomen - RLQ
4/11/24 at 5:15 a.m. on the Abdomen - RUQ
4/11/24 at 2:01 p.m. on the Abdomen - RUQ
4/11/24 at 9:54 p.m. on the Abdomen - RUQ
4/12/24 at 5:59 a.m. on the Abdomen - RLQ
4/12/24 at 1:05 p.m. on the Abdomen - RLQ
4/13/24 at 6:15 a.m. on the Abdomen - RLQ
4/13/24 at 2:12 p.m. on the Abdomen - RLQ

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F 658	Continued From page 29 4/19/24 at 6:03 p.m. on the Abdomen - RLQ 4/19/24 at 9:36 a.m. on the Abdomen - RLQ 4/20/24 at 9:05 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 4/21/24 at 6:51 a.m. on the Abdomen - LLQ 4/27/24 at 5:35 a.m. on the Abdomen - RLQ 4/27/24 at 2:43 p.m. on the Abdomen - RLQ During a concurrent interview and record review on 6/5/2024, at 10:24 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 11's Order Summary Report, including the discontinued orders, the Location of Administration site of heparin injection for the month of 4/2024 to 5/2024. The ADON stated there were multiple repeated sites of heparin subcutaneous administration between 4/2024 to 5/2024. The ADON stated the sites of heparin administration should be rotated to prevent bleeding, bruising, and irritation on the frequently administered sites. A review of the facility provided manufacturer's guideline on the use of Heparin, with U.S. initial approval in 1939, indicated, to use a different site for each injection. Hemorrhage, including fatal events, has occurred in patients receiving heparin. Use caution in conditions with increased risk of hemorrhage. Monitor for signs and symptoms and discontinue if indicative of HIT and HITTS. Most common adverse reactions are hemorrhage, thrombocytopenia, HIT and HITTS, injection site irritation, general sensitivity reactions, and elevations of aminotransferase levels. c. A review of Resident 5's Admission Record indicated the facility admitted Resident 5 on 1/25/2021 with diagnoses including, but not	F 658		

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limited to, type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and transient cerebral ischemic attack (a brief episode of neurological [relating to the brain] dysfunction resulting from an interruption in the blood supply to the brain or the eye).

A review of Resident 5's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/13/2024, indicated Resident 5 had moderate cognitive impairment (difficulty understanding and making decisions), required supervision with eating, and required maximal assistance or was dependent on facility staff for other activities of daily living, including hygiene, toileting, and surface to surface transfers. The MDS further indicated Resident 5 was at risk for pressure ulcers and received treatments, including pressure reducing device for the bed.

A review of Resident 5's Order Summary Report indicated Resident 5 was ordered the following:
- On 7/4/2023, Insulin Glargine Solution (a type of insulin) 100 units (a unit of measure) per milliliter (ml - a unit of measure for volume) inject 10 units subcutaneously at bedtime for diabetes.
- On 9/18/2023, Insulin Aspart (also known as NovoLog Solution, a type of insulin) inject subcutaneously two times a day for type two diabetes.

A review of Resident 5's Medication Administration Record (MAR), dated 5/2024, indicated Resident 5 was administered the following:
- On 5/4/2024, at 6:39 a.m., NovoLog Solution subcutaneously in the left lower quadrant (LLQ) of the abdomen (area around the stomach).

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- On 5/4/2024, at 8:25 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 5/4/2024, at 8:26 p.m., insulin glargine subcutaneously in the LLQ of the abdomen.
- On 5/6/2024, at 8:35 p.m., NovoLog Solution subcutaneously in the right lower quadrant (RLQ) of the abdomen.
- On 5/7/2024, at 6:35 a.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/7/2024, at 9:08 p.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/9/2024, at 9:19 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/10/2024, at 8:19 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/13/2024, at 5:39 a.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/13/2024, at 8:53 p.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/13/2024, at 8:56 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/14/2024, at 9:13 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/15/2024, at 8:56 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/16/2024, at 5:49 a.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 5/16/2024, at 9:23 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 5/19/2024, at 8:22 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/20/2024, at 10:27 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/21/2024, at 6:47 a.m., NovoLog Solution subcutaneously in the LLQ of the

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abdomen.
- On 5/21/2024, at 8:33 a.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.

A review of Resident 5's MAR, dated 6/2024, indicated Resident 5 was administered the following:
- On 6/1/2024, at 8:43 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 6/1/2024, at 8:54 p.m., insulin glargine subcutaneously in the LLQ of the abdomen.
- On 6/2/2024, at 9:05 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 6/2/2024, at 9:12 p.m., insulin glargine subcutaneously in the LLQ of the abdomen.

During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 4:50 p.m., Resident 5's MAR, dated 5/2024 and 6/2024, was reviewed and the ADON confirmed there were entries in the MAR indicating the injection sites were not rotated. The ADON further stated insulin injections sites should be rotated and not be injected in the same site because it can potentially lead to bruising, bleeding, and or lipodystrophy.

A review of the insulin glargine patient package insert provided by the facility, dated 2023, indicated to change (rotate) injection sites within the area chosen with each dose to reduce the risk of getting lipodystrophy and localized cutaneous amyloidosis (skin with lumps). The package insert further indicated to not use the exact same spot for each injection, not inject where the skin has pits, is thickened, or has lumps, where the skin in tender, bruised, scaly or hard, scars, or damaged skin.

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F 658	Continued From page 33 A review of the NovoLog package insert provided by the facility, last revised 2/2023, indicated to rotate the injection site within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents receive care to prevent pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for one of one sampled residents investigated under the pressure ulcer care area (Resident 5) when Resident 5's low air loss mattress (LALM - a pressure reducing device) was not set according to the manufacturer's guidelines.	F 686	F686 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident 5's low air loss (LAL) mattress was set according to manufacturer's guidelines by the Licensed Nurse (LN) on 6/4/24. How the facility identified other residents having the potential to be affected by the deficient practice: Residents that utilize a LAL mattress were reviewed by the LN on 6/4/24 to ensure that the mattresses were set to the manufacturer's guidelines. Issued identified were corrected. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The LNs were in-serviced by the Director of Staff Development (DSD) on 6/22/24 and 6/24/24 regarding the appropriate settings of the LAL mattress according to manufacturer's guidelines in order to prevent pressure injuries.	

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F 686	Continued From page 34 This deficient practice had the potential for the resident to develop pressure ulcers. Findings: A review of Resident 5's Admission Record indicated the facility admitted Resident 5 on 1/25/2021 with diagnoses including, but not limited to, type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and transient cerebral ischemic attack (a brief episode of neurological [relating to the brain] dysfunction resulting from an interruption in the blood supply to the brain or the eye). A review of Resident 5's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/13/2024, indicated Resident 5 had moderate cognitive impairment (difficulty understanding and making decisions), required supervision with eating, and required maximal assistance or was dependent on facility staff for other activities of daily living, including hygiene, toileting, and surface to surface transfers. The MDS further indicated Resident 5 was at risk for pressure ulcers and received treatments, including pressure reducing device for the bed. A review of Resident 5's Order Summary Report, dated 6/4/2024, indicated an order for a pressure redistribution mattress - low air loss every shift for skin management. A review of Resident 5's Care Plan, dated 2/15/2024, indicated Resident 5 had altered skin integrity related to pressure ulcer on the sacrum with interventions including, but not limited to, low air loss mattress for skin management.	F 686	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The DSD or designee will audit weekly for 3 months for the appropriate settings of the LAL mattress according to manufacturer's guidelines. Any issues identified will be corrected. The DSD will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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F 686	Continued From page 35	F 686		

A review of Resident 5's Care Plan, dated 2/15/2024, indicated Resident 5 had altered skin integrity related to pressure ulcer on the right buttock with interventions including, but not limited to, low air loss mattress for skin management.

A review of Resident 5's Weight Summary, dated 6/4/2024, indicated Resident 5 weighed 195 pounds (a unit of measure for mass).

During a concurrent observation and interview with Certified Nursing Assistant (CNA) 1, on 6/4/2024, at 8:59 a.m., inside Resident 5's room, CNA 1 confirmed Resident 5 was lying down in bed on a LALM with the device's weight setting set to 660 pounds to 750 pounds. CNA 1 stated LALM settings should be set to the resident's weight and if not set correctly, the LALM would not prevent pressure ulcers from occurring.

During an interview with the Director of Staff Development (DSD), on 6/4/2024, at 2:55 p.m., the DSD stated the LALM should be set to the resident's weight. The DSD further stated if the LALM is not set correctly, it can potentially lead to skin breakdown and resident discomfort.

During an interview with Treatment Nurse (TX) 1, on 6/5/2024, at 11:25 a.m., TX 1 stated Resident 5 is currently on skin maintenance care and is on a LALM. TX 1 stated the LALM should be set to the resident's weight. TX 1 further stated if the setting on the LALM is set too high, it can increase the pressure on the resident's skin and there is a possibility that the resident's pressure ulcer can reopen.

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F 686	Continued From page 36 During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 6/5/2024, at 4:50 p.m., Resident 5's medical record was reviewed and the ADON confirmed Resident 5 weighed 195 pounds and was ordered a LALM. The ADON stated the LALM should be set to the resident's weight and if the LALM is set incorrectly, there is a potential for the resident's wounds to reopen. A review of the LALM Manufacturer's Guidelines provided by the facility, undated, indicated users can adjust the air mattress to a desired firmness according to the resident's weight and comfort.	F 686		
F 689 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision to prevent accidents by failing to ensure medications were not left unattended and readily available for one of four sampled residents (Resident 196) reviewed under the Accidents care area. This deficient practice had the potential to result in residents obtaining medication without staff knowledge resulting in accidental ingestion	F 689	F689 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: On 6/4/24 The medications were removed by the LVN and confirmed by the ADON that medications were no longer at bedside as well as the gel. Resident 196 discharged from the facility 06/10/2024. How the facility identified other residents having the potential to be affected by the deficient practice: A review of residents' rooms was conducted by the Licensed Nurses (LNs) on 6/4/24 to ensure no medications were stored at their bedside unless they had a physician order to self-administer medications. No other residents were affected by the deficient practice.	

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F 689	Continued From page 37 causing harm to residents. Findings: A review of Resident 196's Admission Record indicated the facility admitted the resident on 4/23/2024 with diagnoses that included fracture (broken bone) of the sacrum (region at the bottom of the spine), hypertension (high blood pressure), immunodeficiency (decreased ability of the body to fight infections and other diseases) and need for assistance with personal care. A review of Resident 196's Minimum Data Set (MDS - an assessment and care screening tool) dated 4/26/2024, indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident required partial assistance with oral hygiene and upper body dressing, maximum assistance with lower body dressing and putting on footwear and was dependent on staff for bathing and toileting. A review of Resident 196's Self-Administration of Medication Assessment form, dated 4/23/2024, indicated the resident did not request self-administration of medications and there was no agreement to the terms and policies for self-administration of medications. During an observation on 6/4/2024 at 8:54 a.m., Licensed Vocational Nurse 2 (LVN 2) stood at Resident 196's bedside and measured the resident's blood pressure. Observed two pill bottles and one topical gel on the resident's nightstand. During an observation on 6/4/2024 at 9:15 a.m.,	F 689	Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The Director of Staff Development (DSD) in-serviced the LNs on 6/20/24 regarding the facility policy on medication safety and storage. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The DSD or designee will audit weekly for 3 months for safe medication storage and no medications left or stored at residents' bedside unless the resident has a physician order to self-administer medications. Any issues identified will be corrected. The DSD will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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LVN 2 entered Resident 196's room, stood at the resident's bedside facing the direction of the nightstand, and administered acetaminophen (a medication to treat pain) to Resident 196. Observed two pill bottles and one topical gel on the resident's nightstand. LVN 2 exited Resident 196's room.

During a concurrent observation and interview on 6/4/2024 at 9:20 a.m. observed Resident 196 lying in bed. Observed two pill bottles and one topical gel on the resident's nightstand and an additional pill bottle on the resident's bedside rolling table.

Resident 196 stated the pill bottles belonged to her and the nurses sometimes helped her take them and sometimes they didn't. Resident 196 stated she takes the pills in the morning for her stomach, and she did not know what the gel was for.

During a concurrent observation and interview on 6/4/2024 at 9:25 a.m., Certified Nursing Assistant 4 (CNA 4) stood at Resident 196's bedside and stated the following:
1. On Resident 196s nightstand, there was one bottle of Arthro Max gel (a topical medication used to treat pain).
2. On Resident 196s nightstand, there was one bottle of vitamin D3 + K2 (a supplement medication)
3. On Resident 196s nightstand, there was on bottle of magnesium citrate (a supplement medication)
4. On Resident 196s rolling bedside table, there was one bottle of zinc picolinate (a supplement medication).

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CNA 4 further stated she was not sure what the medications were for and maybe the resident's family brought them. CNA 4 exited Resident 196's room and did not remove the medications from the resident's bedside.

During a concurrent observation and interview on 6/4/2024 at 9:31 a.m., observed LVN 2 enter Resident 196's room. LVN 2 stated when she was previously in Resident 196's room, she observed bottles on the nightstand, but she thought the bottles were shampoo and she did not look any further. LVN 2 stated Resident 196 was not allowed to take medications on her own or to have medications left at her bedside. LVN 2 stated she would remove the medications. Observed LVN 2 remove three bottles and exited the resident's room. Observed the Arthro Max topical gel bottle remained on the nightstand.

During a concurrent observation and interview on 6/4/2024 at 9:50 a.m., CNA 4 entered Resident 196's room and stated the Arthro Max gel bottle remained on the resident's nightstand. CNA 4 exited Resident 196's room without removing the gel.

During a concurrent interview and record review on 6/4/2024 at 9:55 a.m. with the Assistant Director of Nursing (ADON), reviewed Resident 196's physician orders and progress notes. The ADON stated if a resident wants to self-administer medications there must be an assessment and a discussion with the physician, resident and resident's family, and the interdisciplinary team. The ADON stated the resident has poor safety awareness and did not have an assessment or physicians order for self-administration of medication and the resident

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should not have medication left at bedside.

During a concurrent interview and record review on 6/4/2024 at 10 a.m., with Treatment Nurse 1 (TX 1) reviewed Resident 196's physician orders and stated no topical medications should be left at bedside. TX 1 stated CNAs and nurses should make rounds including resident environment assessment and monitoring for medications at bedside. TX 1 stated medications should not be left at bedside because residents may take the medication without a physician's order, and they may overdose or overuse a medication. TX 1 stated Resident 196 had an order for a similar topical medication that may result in overuse if both the ArthroMax and the facility provided topical medication were both applied.

A review of the facility provided policy and procedure titled, "Self-Administration of Medications," last reviewed 1/15/2024, indicated residents have the right to self-administer medications if the interdisciplinary team was determined that it is clinically appropriate and safe for the resident to do so. As part of the over-all evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for residents. If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party.

A review of the facility provided policy and procedure titled, "Safety Precautions, General,"

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F 689	Continued From page 41 last reviewed 1/15/2024, indicated all personnel shall follow general safety precautions established by the facility. Follow established safety precautions as well as those that may become necessary or appropriate.	F 689		
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. §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	F 690	F690 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident 249's urinary catheter tubing was uncoiled and bag was removed off the floor, cleaned and disinfected by the Licensed Nurse (LN) on 6/4/24. How the facility identified other residents having the potential to be affected by the deficient practice: Residents with urinary catheter bags were reviewed by the LNs on 6/4/24. No other residents were affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The nursing staff were in-serviced by the Director of Staff Development (DSD) on 6/4/24 and 6/5/24	

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F 690	Continued From page 42 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 who were incontinent (lacks voluntary control over urination) of bladder (organ in the pelvis that stores urine) received appropriate treatment and services to prevent urinary tract infections (UTI, common infections that happen when bacteria infect the urinary tract) for two out of three sampled residents (Resident 249 and 40) reviewed under the urinary catheter (a tube that is inserted into the bladder, allowing urine to drain) care area by: 1. Failing to keep Resident 249's urinary catheter tubing from coiling and allowing the contents to flow freely into the indwelling urinary catheter bag (container that connects to a urinary catheter and collects urine). 2. Failing to keep Resident 249 and Resident 40's indwelling urinary catheter bag from touching the floor. The deficient practices had the potential for residents to develop catheter associated urinary tract infection (CAUTI, an infection of the urinary tract caused by a tube [urinary catheter] that has been placed to drain urine from the bladder [an organ inside the body that stores urine until it is can be excreted]). Findings:	F 690	regarding the facility policy for urinary catheters and the importance of keeping the tubing uncoiled and the bag not touching the floor. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The DSD or designee will audit weekly for 3 months of resident urinary catheters to ensure the tubing is uncoiled and the bag not touching the floor. Any issues identified will be corrected. The DSD will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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1. A review of Resident 249's Admission Record indicated the facility admitted the resident on 5/31/2024, with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest task), acute kidney failure (abrupt decrease in kidney function), and retention of urine (a condition in which urine cannot empty from the bladder).

A review of Resident 249's History and Physical (H&P), dated 6/3/2024, indicated the resident can make needs known but cannot make medical decisions.

A review of Resident 249's Order Summary Report, dated 5/31/2024, indicated an order for indwelling foley catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) 16 French (F, catheter size)/10 milliliters (ml, a unit of volume).

During a concurrent observation and interview on 6/4/2024, at 9:18 a.m., with Certified Nursing Assistant 3 (CNA 3), inside Resident 249's room, observed Resident 249's urinary catheter tubing kinked and the bag touching the floor. CNA 3 stated they should keep the catheter bag off the floor for infection control and the tubing should be free of kinks so the urine can flow freely.

During an interview on 6/5/2024, at 10:30 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the urinary catheter should be kept off the floor to prevent ascending infection (the most common route by which bacteria gain access into the urinary tract) to the resident. The ADON stated the urinary catheter tubing should

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be inspected frequently for kinks to prevent backflow of the urine to the bladder that could result in infection.

A review of the facility's recent policy and procedure titled, "Catheter Care, Urinary," last reviewed on 1/15/2024, indicated the purpose of this procedure is to prevent catheter-associated urinary tract infections. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Be sure the catheter tubing and drainage bag are kept of the floor. Provide privacy.

2. A review of Resident 40's Admission Record indicated the facility admitted the resident on 5/9/2024, with the diagnoses that included, but not limited to benign prostatic hyperplasia (a condition that enlarges the small reproductive organ found in males that surrounds the tube that empties the bladder), UTI, and urine retention.

A review of Resident 40's History and Physical (H&P), dated 5/12/2024, it indicated the resident was readmitted to facility on 5/9/2024 from a general acute care hospital (GACH) due to a UTI and indwelling catheter replacement. The H&P indicated the resident has the capacity to understand and make decisions.

A review of Resident 40's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/12/2024, it indicated Resident 40 had mild cognitive impairment. The MDS also indicated Resident 40 required moderate assistance with bed mobility, dressing, and personal hygiene.

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F 690	Continued From page 45 A review of Resident 40's Order Summary Report printed on 6/5/2024, it indicated on 5/10/2024, Resident 40's physician ordered indwelling catheter 18 French (indwelling catheter size) connected to a drainage bag for urinary retention and indwelling catheter care every shift. During an observation on 6/4/2024, at 9:46 a.m., inside Resident 40's room, Physical Therapist (PT) 1 put Resident 40's indwelling catheter bag onto the floor and assisted the resident into bed from the resident's wheelchair. During an interview on 6/4/2024 at 9:50 a.m. with PT 1, PT 1 stated the Resident wanted to get back into bed quickly and placed the indwelling catheter bag down to expedite (make faster) the transfer from wheelchair to bed. PT 1 stated the resident is at an increased risk of infection if the indwelling catheter bag is on the floor. During an interview on 6/4/2024 with Assistant Director of Nursing (ADON), ADON stated staff must adhere to standards of practice by keeping the indwelling catheter bag off the floor. ADON further stated Resident 40 could develop a UTI causing confusion, falls and rehospitalization. A review of the facility's policy and procedure (P&P) titled, "Catheter Care, Urinary," last reviewed 1/15/2024, it indicated, "The purpose of this procedure is to prevent catheter-associated urinary tract infections. Be sure the catheter tubing and drainage bag are kept off the floor."	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids.	F 694	F694	

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F 694	Continued From page 46 Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to label the intravenous (IV - a tube inserted into the vein that delivers medication) medication bag and tubing for one of one sampled resident (Resident 36). This deficient practice had the potential to increase Resident 36's risk for complications from IV medication administration such as bacteria growth in the tubing, wrong rate (how fast to give), wrong amount and wrong time. Findings: A review of Resident 36's Admission Record indicated the facility admitted on 5/8/2024, with diagnoses that included, but not limited to malignant neoplasm (cancerous tumor that can spread) of left female breast, secondary malignant neoplasm (cancerous tumor arising from an existing tumor) of bone, chronic kidney failure (when kidneys are damaged over time and can't filter blood correctly) and hypercalcemia (when the calcium level in the blood becomes too high.) A review of Resident 36's History and Physical (H&P), dated 5/9/2024, it indicated the resident was admitted to the facility on 5/8/2024 from a general acute care hospital (GACH) due to severe hypercalcemia associated with chronic kidney failure. The H&P also indicated the	F 694	F694 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: On 6/4/24 LVN1 dated and labeled IV bag for resident 36. How the facility identified other residents having the potential to be affected by the deficient practice: Residents on IV therapy were reviewed by the Licensed Nurse (LN) on 6/4/24. No other residents were affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The Director of Nursing in-serviced the LNs on 6/15/24 and 6/26/24 regarding the facility policy for IV therapy and the importance of labeling IV medications with the resident’s name, medication, date/time hung and the rate of infusion; and when to change the IV tubing set up. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system:	

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F 694	Continued From page 47 resident had the capacity to understand and make decisions. A review of Resident 36's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/11/2024, it indicated Resident 36 had the ability to make self-understood and had the ability to understand others. The MDS indicated Resident 36 required moderate assistance with bed mobility, dressing, toilet use, and personal hygiene. A review of Resident 36's physician's order printed on 5/7/2024, it indicated Resident 36's physician (MD) ordered on 6/3/2024, Sodium Chloride 0.9% (NaCl - a fluid mixture of water and salt) "Use 50 ml/hr (milliliters per hour) intravenously (IV given through the vein) every shift for hypercalcemia for 2 days until finished for 2 L (liter)." A review of Resident 36's Abnormal lab Hypercalcemia Care Plan dated 6/3/2024, the care plan indicated to IV hydrate with NaCl per MD order. A review of Resident 36's IV site Care Plan dated 6/3/2024, the care plan indicated to change IV tubing for continuous hydration every 72 hours and label IV tubing with date change. During an observation, on 6/4/2024, at 8:55 a.m., in Resident 36's room, Resident 36 was bed connected to a hanging IV medication bag "NaCl 500 ml". The IV medication bag was not labeled with the resident's information, including her name, medication information including any added medication in addition to the NaCl, how much, how fast to give it, when it was started and	F 694	The ADON or designee will monitor residents on IV therapy twice a week for the next 3 months to ensure IV medications are labeled and tubing changed according to the facility policy; and report any findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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F 694	Continued From page 48 by who. The IV tubing connecting the NaCl bag to Resident 36 was not labeled with the date it was last changed. During a concurrent observation and interview on 6/4/2024 at 9:05 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 36's room, Resident 36's IV medication bag "NaCl 500 ml" and tubing connected to the resident did not have a label or date. LVN 1 stated it is dangerous to give any medication without a label because other staff members would not know what was being given, when it was started or how much to give. During an interview on 6/4/2024 at 11:40 a.m. with Assistant Director of Nursing (ADON), ADON stated nurses must follow the standards of practice and label all medications with the resident's name, room number, medication name, date, rate, and the amount. ADON further stated without a labeled start date, other nurses might not know when to change the IV tubing and the resident could develop and infection from bacteria growth. A review of the facility's Policy and Procedure titled "Continuous Infusion of Medication and Infusions," revised on 1/15/2024, it indicated, "Administration sets used for continuous infusion will be changed every 72 hours. Medication/solution containers must be changed at least every 24 hours."	F 694		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700	F700	

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F 700	Continued From page 49 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess the risk of entrapment (an event in which a resident is caught, trapped, or entangled in spaces in or about the bed rail) from side rails (adjustable metal or rigid plastic bars that attach to the bed) and obtain informed consent from the resident or the resident representative prior to installation to two of two sampled residents (Residents 11 and 20) investigated during review of accidents care area. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment, and death of residents.	F 700	F700 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. Resident 11 was re-assessed for the use of their bed rails by the Licensed Nurse (LN) on 6/21/24. 2. Resident 20 discharged from the facility 06/11/2024. How the facility identified other residents having the potential to be affected by the deficient practice: Residents with side rails were reviewed by the LNs on 6/21/24 and 6/22/24. Any issues identified were corrected. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The LN were in-serviced by the Director of Nursing (DON) on 6/4/24, 6/22/24, 6/24/24 regarding the facility policy for resident safety and use of side rails. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system:	

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F 700	Continued From page 50 Findings: 1. A review of Resident 11's Admission Record indicated the facility admitted the resident on 4/5/2024, with diagnoses including age-related osteoporosis (bone loss occurs with aging in all adults), dementia (the loss of cognitive functioning, thinking remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), and abnormal posture. A review of Resident 11's History and Physical (H&P), dated 4/8/2024, indicated the resident had physical debility, muscle weakness, and physical deconditioning. The H&P indicated the resident can make needs known but cannot make medical decisions. A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/8/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident required substantial to maximal assistance on mobility and activities of daily living (ADLs). A review of Resident 11's Order Summary Report did not indicate an order for side rail placement. During an observation on 6/4/2024, at 8:48 a.m., inside Resident 11's room, observed the resident in bed with right half (½)side rail up. During an observation and interview on 6/4/2024, at 12:43 p.m., with the Payroll Staff (PS), inside Resident 11's room, observed the bed of the resident had ½ side rail up with the PS. The PS stated the ½ side rail was up on the resident's	F 700	The DON or designee will audit weekly for 3 months for resident use side rails, especially the assessment for safety, informed consent, physician order and plan of care. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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F 700	Continued From page 51 bed. During a concurrent interview and record review on 6/5/2024, at 10:09 a.m., with the Assistant Director of Nursing (ADON), Resident 11's medical records including assessments, physician orders and informed consents were reviewed. The ADON stated there was no assessment for risk for entrapment and there was no informed consent and physician order obtained prior to installation of the side rails. The ADON stated prior to installation of the side rails there should have been a physician order, a consent for the use of the side rail, and an assessment for risk for entrapment, to ensure resident safety. A review of the facility's recent policy and procedure titled, "Bed Safety and Bed Rails," last reviewed on 1/15/2024, resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.). The use of bed rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. size and weight;	F 700		

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F 700	Continued From page 52 c. sleep habits; d. medication(s); e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; i. cognition; j. communication k. mobility (in and out of bed); and l. risk of falling. A review of the facility's recent policy and procedure titled, "Safety Precautions, General," last reviewed on 1/15/2024, indicated all personnel shall follow general safety precautions established by this facility. Follow manufacturer's directions when using chemicals, equipment, and other supplies. Follow established safety precautions as well as those that may become necessary or appropriate. A review of the facility provided "User-Service Manual Bed Frame 1 (BF 1), undated, indicated the efforts of the FDA and the HBSW culminated in the FDA's release of recommended guidelines intended to reduce the risk of entrapment, including dimensional limits for critical gaps and spaces between bed system components and clinical guidance for assessment and implementation of bed side rails in various health care settings. A review of the facility provided "User-Service Manual Assist Handle 1 (AH 1), undated, indicated an optimal bed system assessment should be conducted on each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in	F 700		

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compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the U.S. Food and Drug Administration.

2. A review of Resident 20's Admission Record indicated the facility admitted the resident on 3/6/2024, with diagnoses including lack of coordination, syncope (fainting or passing out) and collapse, and age-related osteoporosis.

A review of Resident 20's H&P, dated 4/18/2024, indicated the resident had physical debility, muscle weakness, and physical deconditioning. The H&P indicated the resident can make needs know but cannot make medical decisions.

A review of Resident 20's MDS, dated 3/9/2024, indicated the resident usually had the ability to make self-understood and understand others. The MDS indicated the resident required substantial to partial assistance on mobility and activities of daily living (ADLs).

A review of Resident 20's Order Summary Report did not indicate an order for side rail placement.

During an observation on 6/4/2024, at 8:48 a.m., inside Resident 20's room, observed the resident's bed with ½ side rail up on the resident's bed.

During a concurrent interview and record review on 6/5/2024, at 10:09 a.m.,with the Assistant Director of Nursing (ADON), Resident 40's medical records including assessments,

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physician orders and informed consents were reviewed. The ADON stated there was no assessment for risk for entrapment and there was no informed consent and physician order obtained prior to installation of the side rails. The ADON stated prior to installation of the side rails there should have been a physician order, a consent for the use of the side rail, and an assessment for risk for entrapment, to ensure resident safety.

A review of the facility's recent policy and procedure titled, "Bed Safety and Bed Rails," last reviewed on 1/15/2024, resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.). The use of bed rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The resident assessment to determine risk of entrapment includes, but is not limited to:
a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms;
b. size and weight;
c. sleep habits;
d. medication(s);
e. acute medical or surgical interventions;
f. underlying medical conditions;
g. existence of delirium;
h. ability to toilet self safely;

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F 700	Continued From page 55 i. cognition; j. communication k. mobility (in and out of bed); and l. risk of falling. A review of the facility's recent policy and procedure titled, "Safety Precautions, General," last reviewed on 1/15/2024, indicated all personnel shall follow general safety precautions established by this facility. Follow manufacturer's directions when using chemicals, equipment, and other supplies. Follow established safety precautions as well as those that may become necessary or appropriate. A review of the facility provided "User-Service Manual BF 1, undated, indicated the efforts of the FDA and the HBSW culminated in the FDA's release of recommended guidelines intended to reduce the risk of entrapment, including dimensional limits for critical gaps and spaces between bed system components and clinical guidance for assessment and implementation of bed side rails in various health care settings. A review of the facility provided "User-Service Manual AH 1, undated, indicated an optimal bed system assessment should be conducted on each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the U.S. Food and Drug Administration.	F 700		

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F 726 SS=D	Continued From page 56 Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs for	F 726 F 726	F726 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident 249 was re-assessed for the use of his gastric tube (G-tube) by the DON on 6/5/24. Assessment indicated G-tube was patent and medications were administered via G-tube using gravity and no other issues were identified. The Director of Nursing (DON) in-serviced the LN's on 6/6/24, 6/19/24 and 6/24/24 regarding the facility policy for administering medications via a G-tube, especially administering medications via gravity instead of a slow push method. The pharmacy consultant conducted a med-pass observation and in-serviced LVN (2) on 6/11/24 for administering medication via G-tube. How the facility identified other residents having the potential to be affected by the deficient practice: Medications administered via residents with G-tubes were observed by the DON on 6/5/24. No other residents were identified to be affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur:	

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F 726	Continued From page 57 one of five sampled facility staff members reviewed under the sufficient and competent staffing care area (Licensed Vocational Nurse [LVN] 2) when LVN 2 did not flush Resident 249's gastrostomy tube (GT - a tube inserted through the wall of the abdomen directly into the stomach used to provide nutrition, hydration, and or medications) via gravity (method of sending fluids through the GT in a downward direction using the force of gravity) and verbalized using a slow push method (using a syringe and pushing the plunger slowly to administer medications or fluids) when administering medications via the GT instead of administering via gravity. This deficient practice had the potential to cause discomfort for the resident and or cause the GT to dislodge from the resident. Cross-reference F755, F759, F842 Findings: A review of Resident 249's Admission Record indicated the facility admitted Resident 249 on 5/31/2024 with diagnoses including, but not limited to, gastrostomy status (creation of an artificial external opening into the stomach for nutritional support) and retention of urine. A review of Resident 249's Physician Progress Note, dated 6/3/2024, indicated Resident 249 can make his needs known, but cannot make medical decisions, and had a GT. A review of Resident 249's Order Summary Report indicated Resident 249 was ordered the following: - On 6/1/2024, enteral (involving or passing	F 726	The DON in-serviced the LNs on 6/6/24, 6/19/24 and 6/24/24 regarding the facility policy for administering medications via a G-tube, especially administering medications via gravity instead of a slow push method. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The Director of Staff Development (DSD) of designee will randomly audit weekly on all 3 shifts medications administered via a G-tube to ensure the medications are administered via gravity instead of a slow push method and report the findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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through the intestine [an organ in the digestive system]) feed order every shift for GT feeding Osmolite 1.5 (a type of tube feeding formula) at 45 ml per hour for 20 hours to provide 900 ml per 13,500 calories (a unit of energy, often used to express the nutritional value of foods) per 24 hours via enteral pump from 2:00 p.m. to 10:00 a.m., or until the dose limit is met.
- On 6/1/2024, check placement of GT before beginning a feeding and before administering medications.
- On 6/1/2024, flush GT with 30 milliliters (ml - a unit of measure for volume) warm water after medication administration.

During a concurrent observation and interview with LVN 2, on 6/5/2024, at 9:41 a.m., inside Resident 249's room, LVN 2 disconnected Resident 249 from their tube feeding. LVN 2 stated she was going to flush the GT with water to clear the resident's GT. LVN 2 drew up water from a cup using a syringe, connected the syringe to Resident 249's GT, and pushed the plunger in the syringe and administered water through Resident 249's GT. LVN 2 stated when administering medications via GT, each medication is administered separately with a flush of water in between each medication. LVN 2 stated unless specified, she would not administer GT medications via gravity and would slowly push each medication.

During a concurrent interview and record review with the Director of Staff Development (DSD), on 6/5/2024, at 3:05 p.m., LVN 2's employee file was reviewed, and the DSD confirmed LVN 2 did not have a skills checklist for GT medication administration. The DSD stated the facility does not have GT medication administration as part of

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the new orientation checklist or the skills checklist. The DSD stated when the facility has a resident with a GT, the Director of Nursing (DON) will provide an in-service regarding GT medication administration. The DSD stated the last in-service related to GT medication administration was conducted on 1/10/2024 and LVN 2 was not present because she was hired on 3/2024. The DSD stated it is not appropriate to flush the GT via slow push and medications should be administered via gravity to see if the resident can tolerate the procedure. The DSD further stated pushing medications or fluids via syringe into a GT can potentially cause discomfort for the residents and possibly dislodge the tubing.

During an interview with the Assistant Director of Nursing (ADON), on 6/5/2024, at 4:50 p.m., the ADON stated medications administered via GT should be administered via gravity and staff should be aware and competent on how to administer medications via GT. The ADON further stated if staff are not competent in administering GT medications via gravity, the staff can potentially cause the resident discomfort, cause the stomach contents to come out, or can possibly cause the GT to dislodge.

A review of the facility's policy and procedure (P&P) titled, "Specific Medication Administration Procedures," last reviewed 1/15/2024, indicated under the section titled, "Enteral Tube Medication Administration," remove the plunger from the syringe and connect the syringe to the tubing, flush the tube with at least 15 ml of water prior to medication administration, administer medication by allowing the medication flow down the tube via gravity.

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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(g). 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. §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 routine drugs to its residents and establish a system of records of receipt and disposition of all controlled drugs	F 755	F755 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. The Licensed Nurses (LNs) were in-serviced by the Director of Nursing (DON) on 6/19/24, 6/26/24 regarding facility policy on reconciliation of narcotic medication and the importance of LNs signing for the shift-to-shift narcotic count. 2. Resident 249 was re-assessed and the physician notified of the missed medication by the LN on 6/5/24. How the facility identified other residents having the potential to be affected by the deficient practice: 1. Narcotic reconciliation shift-to-shift logs were reviewed by the LN for the first week of June 2024. No other issues were identified. 2. Residents' medication administration records were reviewed by the LN for the first week of June 2024. No other issues were identified. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur:	

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F 755	Continued From page 61 (substances that have an accepted medical use, have a potential for abuse, and may also lead to physical or psychological dependence) in sufficient detail to enable an accurate reconciliation when: 1. The facility failed to ensure licensed nursing staff completed documentation indicating reconciliation (a system of recordkeeping that ensures an accurate inventory of medications that have been received, dispensed, and administered) of controlled medications at every change of shift on the Controlled Substance / MAR (Medication Administration Record) Change of Shift Audit form for one of one medication carts (Medication Cart 2) reviewed during the Medication Storage task. 2. The facility failed to administer medication to one of seven sampled residents reviewed during the medication administration task (Resident 249). These deficient practices had the potential for inaccurate reconciliation of controlled medication and placed the facility at potential for inability to readily identify loss and drug diversion (illegal distribution of prescription drugs for their use for unintended purposes) of controlled medications and resulted in the resident not receiving their prescribed medication. Cross-reference F726, F759, F842 Findings: 1. During a concurrent medication storage observation of Medication Cart 2, interview, and record review on 6/4/2024 at 4:13 p.m. with	F 755	1. The LNs were in-serviced by DON on 6/19/24 and 6/26/24 regarding facility policy on reconciliation of narcotic medication and the importance of LNs signing for the shift-to-shift narcotic count. 2. The LNs were in-serviced by the DON on 6/5/24, 6/18/24 and 6/19/24, 6/26/24 regarding facility policy for medication administration and the importance of administering medications as ordered. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The Medical Records Director or designee will audit daily for 3 months for the reconciliation of narcotic medications and the administration of residents' medications as ordered and will report any findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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Licensed Vocational Nurse 2 (LVN 2) at Medication Cart 2, reviewed the Controlled Substance / MAR Change of Shift Audit forms dated 5/13/2024 to 6/2/2024. LVN 2 stated at every change of shift the oncoming and outgoing charge nurse together count all the narcotics and document on the audit form. LVN 2 stated both the oncoming and outgoing nurse should sign the form. LVN 2 reviewed Controlled Substance / MAR Change of Shift Audit forms dated 5/13/2024 to 6/2/2024 and noted the following missing entries:
-On 5/13/2024, missing the 3 p.m. oncoming charge nurse signature.
-On 5/13/2024, missing the 11 p.m. outgoing charge nurse signature.
-On 5/17/2024, missing the 3 p.m. outgoing charge nurse signature.
-On 5/20/2024, missing the 3 p.m. oncoming charge nurse signature and missing entry to indicate if the count was correct.
-On 5/20/2024, missing the 11 p.m. outgoing charge nurse signature.
-On 5/24/2024, missing the 7 a.m. oncoming charge nurse signature and missing entry to indicate if the count was correct.
-On 5/24/2024, missing the 3 p.m. outgoing charge nurse signature.
-On 5/27/2024, missing the 7 a.m. oncoming charge nurse signature.
-On 5/29/2024, missing the 3 p.m. oncoming charge nurse signature.
-On 5/29/2024, missing the 11 p.m. outgoing charge nurse signature with missing entry to indicate if the count was correct.
-On 6/2/2024, missing the 11 p.m. outgoing charge nurse signature.

LVN 2 further stated the facility protocol was to

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count the narcotics and sign the form together at the change of shift when the medication cart is handed off from the outgoing nurse to the oncoming nurse. LVN 2 stated narcotics are always counted because they are a controlled substance that alters the behavior and mind of individuals. LVN 2 stated narcotics can also be misused and may go missing and not available to give to the resident when they are needed.

During a concurrent interview and record review on 6/5/2024 at 9:37 a.m. with the Director of Nursing (DON) reviewed the facility policy and procedure regarding controlled substances. The DON stated the key to the narcotics drawer is handed off at the change of every shift when the narcotic count is completed by the incoming and outgoing nurses. The DON stated receiving the key means the oncoming nurse is taking the assignment and responsibility for the medication cart The Don stated there is a sign-in and sign-out sheet to document the transfer of responsibility. The DON stated a blank entry on the sheet means the nurse failed to document their name during the hand off. The DON stated if it was not documented then it did not happen. The DON stated a close eye is kept on narcotics because of the possibility of diversion and for the safety of the public. The DON stated narcotics are prone to abuse and can turn up missing and that is why it is important to document the transfer. The DON stated the facility policy was not followed when the nurse failed to document. The DON stated medication could go missing and there may be a delay in care if the medication is not available for the resident.

A review of the facility provided policy and procedure titled, "Controlled Substances," last

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reviewed 1/15/2024, indicated the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on premises. All keys to controlled substance containers shall be on a single key ring that is different from any other keys. The charge nurse on duty will maintain the keys to controlled substance containers. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DON. The DON shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties and shall give the Administrator a written report of such findings.

2. A review of Resident 249's Admission Record indicated the facility admitted Resident 249 on 5/31/2024 with diagnoses including, but not limited to, gastrostomy status (creation of an artificial external opening into the stomach for nutritional support) and retention of urine.

A review of Resident 249's Physician Progress Note, dated 6/3/2024, indicated Resident 249 can make his needs known, but cannot make medical decisions, and had a gastrostomy tube (GT - a tube inserted through the wall of the abdomen directly into the stomach used to provide nutrition, hydration, and or medications).

A review of Resident 249's Order Summary

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Report, dated 5/31/2024, indicated an order for cholecalciferol (a medication used to supplement Vitamin D [a nutrient the body needs for building and maintaining healthy bones]) oral liquid 125 mcg (micrograms - a unit of measure for mass) per milliliter (ml - a unit of measure for volume), give 125 mcg via GT one time a day for nutritional support.

During a concurrent observation and interview with LVN 2, on 6/5/2024, at 9:41 a.m., outside Resident 249's room, LVN 2 attempted to prepare Resident 249's medications and stated Resident 249 was scheduled to receive cholecalciferol oral liquid 125 mcg per ml via GT. LVN 2 checked the medication cart and stated Resident 249's cholecalciferol medication is not in the cart, and she is unable to administer the resident's medication.

During an interview with the Assistant Director of Nursing (ADON), on 6/5/2024, at 4:50 p.m., the ADON stated if residents do not receive their medications, they would not get the intended effect of the medication. The ADON stated the facility should not wait until medications are down to the last tablet or capsule before it is restocked, and the pharmacy should be notified by staff to reorder medications. The ADON further stated if a medication is not available in form ordered by the physician, the staff should clarify the order with the physician.

During an interview with the Operations Manager (OM), on 6/5/2024, at 5:08 p.m., the OM stated the facility does not keep a stock of cholecalciferol in liquid form and stocks cholecalciferol tablets that are not enteric coated (a barrier applied to oral medications that

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F 755	Continued From page 66 prevents its dissolution or disintegration in the stomach and is contraindicated for crushing). A review of the facility's policy and procedure (P&P) titled, "Medication and Treatment Orders," last reviewed 1/15/2024, indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. The P&P further indicated drugs that are required to be refilled must be ordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available.	F 755		
F 757 SS=E	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 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.	F 757	F757 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. Resident 196 discharged from the facility 06/10/2024. 2. Resident 11's heparin was discontinued on 05/06/2024. How the facility identified other residents having the potential to be affected by the deficient practice: Current residents on anticoagulant therapy were reviewed by the Licensed Nurse (LN) on 6/21/24. No other residents were affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur:	

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F 757	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications to two of two sampled residents (Resident 196 and Resident 11) investigated during review of anticoagulant (a class of medications used to prevent blood clots [clumps that occurs when blood hardens from a liquid to a solid]) care area by: 1. Failing to ensure the order for apixaban (an anticoagulant medication) included an adequate indication (identified, documented clinical rationale for administering a medication) for its use for Resident 196. 2. Failing to ensure adequate monitoring for signs and symptoms for adverse (unwanted) effects of heparin (an anticoagulant medication) for Resident 11. This deficient practice had the potential to result in residents in experiencing adverse consequences of the medications such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. Findings: a. A review of Resident 196's Admission Record indicated the facility admitted the resident on 4/23/2024 with diagnoses that included fracture (broken bone) of the sacrum (region at the bottom of the spine), hypertension (high blood pressure), and atrial fibrillation (a-fib, an irregular and often very rapid heart rhythm that can lead to blood clots in the heart).	F 757	The Director of Nursing (DON) in-serviced the LNs on 6/15/24 and 6/18/24 regarding anticoagulant therapy and the importance of noting its indication and proper monitoring for its use and/or side effects. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The Medical Records Director or designee will audit weekly for 3 months any physician orders for anticoagulation therapy to include indication and monitoring for its use and/or side effects; and will report any findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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A review of Resident 196's Minimum Data Set (MDS - an assessment and care screening tool) dated 4/26/2024, indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident required partial assistance with oral hygiene and upper body dressing, maximum assistance with lower body dressing and putting on footwear and was dependent on staff for bathing and toileting.

A review of Resident 196's physician orders indicated the following orders:
-Apixaban oral tablet 2.5 milligrams (mg, a unit of measurement), give 2.5 mg by mouth two times a day for blood thinner. Dated 4/23/2024.

During a concurrent interview and record review on 6/5/2024 at 12:08 p.m., with MDSC reviewed Resident 196's physician orders. The MDSC stated the order for apixaban should include a specific resident condition but Resident 196's order did not include one. The MDSC stated "blood thinner" is not a medical condition.

During a concurrent interview and record review on 6/5/2024 at 4:47 p.m., with the Assistant Director of Nursing (ADON) reviewed Resident 196's physician orders and the facility policy and procedure regarding medication and treatment orders. The DON stated all resident orders should indicate the type of medication, the dose (amount), the frequency (when to administer), and the indication the medication is ordered for. The ADON stated Resident 196's apixaban order did not indicate a resident condition. The ADON stated the order indicated it was for "blood thinner", but it should have indicated a-fib. The

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ADON stated blood thinning is the action of the medication, not the specific resident condition. The ADON stated the admitting nurse reconciles and enters the resident medication orders into the computer and should have caught this, but it was the responsibility of every nurse administering the medication to notify their supervisor to have the order changed. The ADON stated it was important for the order to specify and adequate indication, so the nurse knows exactly what the medication is treating. The ADON stated the facility policy was not followed because there was no resident condition indicated on the apixaban order.

A review of the facility provided policy and procedure titled, "Medication and Treatment Orders," last reviewed 1/15/2024, indicated orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Orders for medications must include the clinical condition or symptoms for which the medication is prescribed.

b. A review of Resident 11's Admission Record indicated the facility admitted the resident on 4/5/2024, with diagnoses including atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (occurs when the heart muscle does not pump blood as well as it should), and gastritis (inflammation of the lining of the stomach).

A review of Resident 11's History and Physical (H&P), dated 4/8/2024, indicated the resident received heparin every 8 hours for deep vein

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thrombosis (DVT, a blood clot that develops within a deep vein in the body, usually in the leg) prophylaxis (PPX, preventive). The H&P indicated the resident had the capacity to make needs known but unable to make medical decisions.

A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/8/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had moderately impaired cognition (a range of mental processes relating to the acquisition, storage, manipulation, and retrieval of information) and was receiving anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the hear) and antiplatelet drugs (a group of medicines that stop blood cells [called platelets] from sticking together and forming a blood clot).

A review of Resident 11's Order Summary Report, on 6/5/2024, did not indicate any order for monitoring for adverse effects on the use of an anticoagulant (heparin).

A review of Resident 11's Order Summary Report, dated 5/6/2024, indicated an order for heparin sodium (Porcine) injection solution 5000 unit (an amount approximately equivalent to 0.002 milligrams [mg, a unit of weight] of pure heparin)/milliliters (ml, a unit of volume). Inject 1 cubic centimeter (cc, a unit of volume) subcutaneously (beneath, or under, all the layers of the skin) every 8 hours for DVT ppx. Rotate (a method to ensure repeated injections are not administered in the same area) sites of injection. The Order Summary Report did not indicate an order for monitoring for adverse effects on the

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F 757	Continued From page 71 use of heparin. During an interview and record review on 6/5/2024, at 10:24 a.m., with the Assistant Director of Nursing (ADON), reviewed the Resident 11's Order Summary Report, including the discontinued orders, and Medication Administration Record (MAR). The ADON stated heparin was ordered on 4/5/2024 and discontinued on 5/6/2024. The ADON stated the order did not include monitoring for adverse effects. The ADON stated it was important to monitor the resident for adverse effects of heparin and report the adverse effects (such as bleeding and bruising) to the physician so the physician can taper or discontinue the medication for the safety of the resident. A review of the facility provided manufacturer's guideline on the use of Heparin, with U.S. initial approval in 1939, indicated, to use a different site for each injection. Hemorrhage, including fatal events, has occurred in patients receiving heparin. Use caution in conditions with increased risk of hemorrhage. Monitor for signs and symptoms and discontinue if indicative of heparin-induced thrombocytopenia (HIT, a severe complication that can occur in patients exposed to any form or amount of heparin products) and heparin-induced thrombocytopenia thrombosis syndrome (HITTS). Most common adverse reactions are hemorrhage, thrombocytopenia, HIT and HITTS, injection site irritation, general sensitivity reactions, and elevations of aminotransferase levels.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758	F758	

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F 758	Continued From page 72 §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 (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	F 758	F758 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. Resident 39 discharged from the facility 06/04/2024. 2. Resident 29 was reassessed by the Licensed Nurse (LN) on 6/16/24 for the use of buspirone to include appropriate behavior monitoring. 3. Resident 23 was reassessed by the LN on 6/16/24 for the use of quetiapine to include obtaining informed consent, proper indication, and appropriate monitoring for behaviors and side effects. 4. Resident 148 was reassessed by the LN on 6/16/24 for the use of citalopram to include appropriate monitoring for behaviors and side effects. How the facility identified other residents having the potential to be affected by the deficient practice: Current residents prescribed psychotherapeutic medications for the first week of June 2024 were reviewed by the LNs on 6/20/24. Any issues identified have been corrected.	

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F 758	Continued From page 73 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: Based on interview and record review the facility failed to ensure each resident's medication regimen was managed and monitored to promote the resident's highest practicable mental, physical, and psychosocial well-being to four out of four sampled residents (Resident 39, 29, 23, and 148)) selected for unnecessary medications review by failing to: 1.a. Ensure the order for (PRN) lorazepam (a psychotropic medication that affects the mind, emotions, and behavior) was limited to a 14-day duration unless longer timeframe was deemed appropriate by the attending physician for Resident 39. 1.b. Identify and define specific measurable target behaviors (behavior that is targeted for change) related to the use of lorazepam for Resident 39. 2. Complete and document monitoring for behavioral manifestations for the use of buspirone (an anxiolytic, a medication used to treat feelings of fear, dread, uneasiness that may occur as a reaction to stress) for Resident 29. 3.a. Ensure the physician's orders include the appropriate indication, indicate specific target behaviors and specific adverse effects to monitor	F 758	Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The LNs were in-serviced by the Director of Nursing (DON) on 6/24/24 and 6/26/24 regarding the facility policy on the use of psychotropic medications, especially obtaining informed consent, physician order, appropriate indication, monitoring for target behaviors and side effects; and developing a plan of care. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The Medical Records Director or designee will audit weekly for 3 months residents prescribed psychotherapeutic medications for informed consent, proper indication, monitoring for target behaviors and side effects; and a plan of care. Any findings will be reported to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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for the use of quetiapine (antipsychotic - a type of drug used to treat symptoms of psychosis [a condition of the mind that results in difficulties determining what is real and what is not real]) for Resident 23.

b. Ensure informed consent was obtained from the resident and/or their representative prior to administration of quetiapine for Resident 23

4. Ensure the physician's orders include specific target behaviors and adverse side effects to monitor for the use of citalopram (an antidepressant - a type of prescription medicine to treat) for Resident 148.

These deficient practices placed patients at risk for experiencing adverse effects related to their psychotropic (medications that affect brain activities associated with mental processes and behavior) medication therapy possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status.

Findings:

1.a&b A review of Resident 39's Admission Record indicated the facility admitted the resident on 5/8/2024, with diagnoses including acute respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body) with hypoxia (low level of oxygen in the body) and emphysema (a type of lung disease that causes breathlessness).

A review of Resident 39's History and Physical (H&P), dated 5/9/2024, indicated the resident had history of anxiety and was receiving lorazepam

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PRN. The H&P indicated the resident had the capacity to understand and make decisions.

A review of Resident 39's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/11/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had moderately impaired cognition (a range of mental processes relating to the acquisition, storage, manipulation, and retrieval of information).

A review of Resident 39's Order Summary Report, dated 5/8/2024, indicated an order for lorazepam oral tablet 1 milligram (mg, a unit of weight) (Lorazepam). Give 1 tablet by mouth every 8 hours as needed for anxiety.

A review of Resident 39's Care plan titled, "High risk for black box warning signs (the highest safety-related warning that medications can have assigned by the Food and Drug Administration) and symptoms related to the use of Ativan," initiated on 5/8/2024, indicated an intervention to limit dosages and durations to the minimum required.

During a concurrent interview and record review on 6/5/2024, at 9:21 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 39's Physician's Orders and Medication Administration Record (MAR). The ADON stated the physician's order for lorazepam was not limited to 14 days and did not indicate specific behaviors to monitor. The ADON stated PRN psychotropic medications should be limited to 14 days unless the medication was deemed by the physician after evaluation of the resident, that it is

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appropriate for the medication to be extended beyond 14 days to prevent residents from receiving unnecessary medication. The ADON further stated the physician order should include specific behaviors related to anxiety to monitor so the staff can effectively monitor the resident.

A review of the facility's recent policy and procedure titled, "Psychotropic Medication Use," last reviewed on 1/15/2024, indicated psychotropic medications are not prescribed or given in a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.
a. PRN orders for psychotropic medications are limited to 14 days.
Residents receiving psychotropic medications are monitored for adverse consequences.

A review of the facility's recent policy and procedure titled, "Antipsychotic Medications Use," last reviewed on 1/15/2024, indicated antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of the medication.

2. A review of Resident 29's Admission Record indicated the facility admitted the resident on 10/14/2021 and readmitted the resident on 4/17/2024 with diagnoses that included dementia

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(general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), lack of coordination, and presence of artificial hip joint.

A review of Resident 29's Minimum Data Set (MDS - an assessment and care screening tool) dated 4/20/2024, indicated the resident was sometimes able to understand others and sometimes able to make himself understood. The MDS further indicated the resident was dependent on staff for bathing, dressing, and toileting.

A review of Resident 29's physician orders indicated an order for buspirone HCL five milligrams (mg, a unit of measurement) oral tablet, give five mg by mouth two times a day for anxiety manifested by restlessness leading to shortness of breath, dated 4/28/2024.

During an interview and record review on 6/4/2024 at 4:42 p.m., with the Assistant Director of Nursing (ADON) reviewed Resident 29's physician orders, Medication Administration Record for June 2024, and progress notes. The ADON stated Resident 29 had a physician order for buspirone, a psychotropic medication administered due to the resident's manifested behavior of restlessness leading to shortness of breath. The ADON stated psychotropic medications are monitored for side effects and behaviors. The ADON stated behaviors should be monitored because psychotropic drugs have side effects and should not be given if they are not needed. The ADON stated there was no documentation for monitoring for Resident 29's buspirone behavior manifestations of restlessness leading to shortness of breath.

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During a concurrent interview and record review on 6/5/2024 at 9:37 a.m., the Director of Nursing reviewed the facility policy and procedure regarding psychotropic medications. The DON stated psychotropic medications affect the cerebral (brain) system and there are many side-affects that may occur. The DON stated resident behaviors requiring psychotropic medication use should be monitored and documented in the Medication Administration Record (MAR) with ongoing assessments in order to determine if the medication is affective or not with the ultimate goal for the resident to be stabilized on the lowest possible dose (amount of medication). The DON stated decreasing the medication dose could decrease the risk of side effects. The DON stated psychotropic medications in higher doses could lead to sedation affecting the resident. The DON stated the admission nurse and all nurses that administer medication are responsible for ensuring there is a physician's order to monitor resident behaviors requiring psychotropic medication. The DON stated the facility policy for psychotropic medications was not followed because there was no monitoring for Resident 29's behaviors.

During a concurrent interview and record review on 6/5/2024 at 11:52 a.m., the Minimum Data Set Coordinator (MDSC) reviewed Resident 29's physician orders and care plans. The MDSC stated Resident 29 was receiving buspirone, a psychotropic medication. The MDSC stated all psychotropic medication should have behavior monitoring. The MDSC stated it was important to ensure resident behaviors are monitored and the medication is evaluated for effectiveness. The

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MDSC stated the lack of monitoring and evaluating the usage of the medication may result in unnecessary psychotropic medications being administered. The MDSC stated when psychotropic medications are given unnecessarily it could affect the resident's health and safety due to altered cognition leading to the resident possibly falling.

A review of the facility provided policy and procedure titled, "Psychotropic Medication Use," last reviewed 1/15/2024, indicated residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects the brain activity associated with mental processes and behavior. Anti-anxiety medications are subject to prescribing, monitoring, and review requirements specific to psychotropic medications. Psychotropic medication management includes adequate monitoring for efficacy and adverse consequences; and preventing adverse consequences. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's sign and symptoms in order to identify underlying causes. Residents on psychotropic medications receive gradual dose reductions in an effort to discontinue these medications. When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts evaluation of the resident's signs and symptoms.

3.a&b. A review of Resident 23's Admission Record indicated the facility admitted the resident on 4/25/2024 with diagnoses including vascular dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect

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the blood vessels in the brain), repeated falls, and generalized muscle weakness.

A review of Resident 23's History and Physical (H&P) dated 4/28/2024, indicated the resident can make his needs known and did not have the capacity to make medical decisions.

A review of Resident 23's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/28/2024, indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and oral hygiene; substantial/maximal assistance with toileting and bathing; partial/moderate assistance with personal hygiene; dependent on staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 23 received an antipsychotic medication.

A review of Resident 23's Order Summary Report indicated the following orders dated 4/25/2024:
- quetiapine fumarate oral tablet 100 milligrams (mg - a unit of measurement) (quetiapine fumarate) give 200 mg by mouth in the morning for dementia.

- quetiapine fumarate oral tablet 300 mg (quetiapine fumarate) give 300 mg by mouth at bedtime for dementia.

A review of Resident 23's psychiatrist (a medical doctor who can diagnose and treat mental health conditions) consultation notes dated 5/7/2024, indicated to continue quetiapine 200 mg every morning and 300 mg at bedtime for psychosis

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(collection of symptoms that affect the mind, where there has been some loss of contact with reality) manifested by combative behavior striking out at staff.

A review of Resident 23's care plan on resident use of quetiapine fumarate oral tablet initiated on 4/27/2024 with target date of 7/27/2024 indicated the following interventions:
- Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift.

- Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of psychotropic medication being given.

- Monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, extrapyramidal side effects (EPS - drug-induced movement disorders such as shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person

- Monitor/record occurrence of target behavior symptoms and document per facility protocol.

During an interview on 6/5/2024 10:20 a.m., with Pharmacist 1 (Pharm 1), Pharm 1 stated the dementia diagnosis for the use of quetiapine was not correct. Pharm 1 stated there was no physician's order to monitor for adverse side effects and indicate the specific target behaviors

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to monitor for the use of quetiapine. Pharm 1 stated she missed to write a recommendation for a physician's order to monitor adverse side effects and episodes of specific behavior every shift when she conducted the Monthly Medication Regimen Review (MMRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) for the residents on 5/6/2024. Pharm 1 stated there should be a physician's order to monitor the side effects and behavior episodes to ensure effectiveness of the medication and to ensure resident safety. Pharm 1 stated lack of monitoring for target behaviors and side effects of psychotropic use may lead to unnecessary use of the medication which could lead to incidents of fall due to altered cognition.

During a concurrent interview and record review on 6/5/2024 at 10:42 a.m., with the MDS Coordinator (MDSC) reviewed Resident 23's medical record including physician's order, care plans, and informed consent. The MDSC verified the diagnosis of dementia for the use of quetiapine is not appropriate and the psychiatrist consultation note dated 5/6/2024 indicated psychosis as the diagnosis. The MDSC stated the psychiatrist's diagnosis of psychosis for Resident 23 should have been discussed and clarified with the attending physician (AP) and an order should have been obtained that indicated psychosis as the indication for the use of quetiapine. The MDSC stated there was no informed consent obtained from the resident or resident representative prior to start of the medication. The MDSC stated there was no physician's order to monitor Resident 23's combative behavior by striking out at staff and adverse side effects every

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shift for the use of quetiapine. The MDSC stated there should have been an order to monitor the combative behavior by striking out at staff and to monitor for any adverse side effects to evaluate effectiveness of the medication and ensure the resident's health and safety. The MDSC stated an informed consent should have been obtained from the resident or their representative to ensure they (resident and their representative) are aware of the current dosage the resident will receive and the risks and benefits of the psychotropic medication.

During an interview on 6/5/2024 at 4:30 p.m., the Assistant Director of Nursing (ADON), the ADON stated Resident 23's diagnosis of dementia is not appropriate for the use of quetiapine and should have been clarified with the physician. The ADON stated psychotropic medications including antipsychotics should have an appropriate diagnosis, physician's order for monitoring of behaviors and adverse side effects every shift to monitor effectiveness of the medication and to ensure the side effects of the medication do not affect the resident health and safety. The ADON stated any psychotropics should have an informed consent prior to administration of the medication start to ensure the resident and/or their representative are aware of the current dosage and the risks and benefits of taking the medication.

A review of the facility provided policy and procedure titled, "Psychotropic Medication Use," last reviewed 1/15/2024, indicated the following:
- Residents will not receive medications that are not clinically indicated to treat a specific condition.
- A psychotropic medication is any medication that affects the brain activity associated with

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mental processes and behavior.
- Psychotropic medication management includes adequate monitoring for efficacy and adverse consequences; and preventing adverse consequences.
- Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's sign and symptoms in order to identify underlying causes.
- When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts evaluation of the resident's signs and symptoms.

4. A review of Resident 148's Admission Record indicated the facility admitted the resident on 5/27/2024 with diagnoses including dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), repeated falls, and depression (a constant feeling of sadness and loss of interest, which stops a person from doing normal activities).

A review of Resident 148's History and Physical (H&P) dated 5/30/2024, indicated the resident can make his needs known and did not have the capacity to make medical decisions.

A review of Resident 148's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/30/2024, indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating and oral hygiene; substantial/maximal assistance with toileting and bathing; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that

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must be accomplished every day for an individual to thrive). The MDS indicated Resident 148 received antidepressant.

A review of Resident 148's Order Summary Report indicated an order dated 5/27/2024 for citalopram hydrobromide tablet 20 milligrams (mg - a unit of measurement) give one (1) tablet by mouth 1 time a day for depression manifested by facial sadness.

During a concurrent interview and record review on 6/5/2024 at 10:42 a.m., with MDS Coordinator (MDSC), reviewed Resident 148's medical record including physician's order, care plans, and Medication Administration Record (MAR). The MDSC verified there was no physician's order to monitor the target behavior facial sadness, and no order to monitor for adverse side effects every shift for the use of citalopram. The MDSC stated there should have been an order to monitor the resident's target behavior and to monitor for adverse side effects to evaluate effectiveness of the medication and ensure the resident's health and safety.

During an interview on 6/5/2024 at 4:30 p.m., the Assistant Director of Nursing (ADON) stated psychotropic medications should have a physician's order for monitoring of behaviors and adverse side effects every shift. The ADON stated Resident 148 should have monitoring for episodes of depression manifested by facial sadness and monitoring for adverse side effects to ensure the resident's health and safety and to evaluate the effectiveness of the medication.

A review of the facility provided policy and procedure titled, "Psychotropic Medication Use,"

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F 758	Continued From page 86 last reviewed 1/15/2024, indicated the following: - Residents will not receive medications that are not clinically indicated to treat a specific condition. - A psychotropic medication is any medication that affects the brain activity associated with mental processes and behavior. - Psychotropic medication management includes adequate monitoring for efficacy and adverse consequences; and preventing adverse consequences. - Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's sign and symptoms in order to identify underlying causes. - When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts evaluation of the resident's signs and symptoms.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent (%). There were two medication errors out of 25 opportunities resulting in an overall medication error rate of 8% affecting one out of seven sampled residents observed for medication administration (Resident 249) when Resident 249 did not receive cholecalciferol (a medication used to supplement Vitamin D [a nutrient the body	F 759	F759 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident 249 was reassessed and the physician notified of the missed medication by the Licensed Nurse (LN) on 6/5/24. How the facility identified other residents having the potential to be affected by the deficient practice: All residents medication administration records were reviewed by the DON/ designee and the Medical Records Director for any missed medications during the first week of June 2024. No other issues were identified. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur:	

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F 759	Continued From page 87 needs for building and maintaining healthy bones]) and fluticasone (medication used to relieve seasonal and year-round allergic and non-allergic nasal symptoms) as ordered by the resident's physician. This deficient practice had the potential for the resident's health and well-being to be negatively impacted. Cross-reference F726, F755, F842 Findings: A review of Resident 249's Admission Record indicated the facility admitted Resident 249 on 5/31/2024 with diagnoses including, but not limited to, gastrostomy status (creation of an artificial external opening into the stomach for nutritional support) and retention of urine. A review of Resident 249's Physician Progress Note, dated 6/3/2024, indicated Resident 249 can make his needs known, but cannot make medical decisions, and had a gastrostomy tube (GT - a tube inserted through the wall of the abdomen directly into the stomach used to provide nutrition, hydration, and or medications). A review of Resident 249's Order Summary Report indicated Resident 249 was ordered the following: -On 5/31/2024, fluticasone propionate nasal suspension 50 micrograms (mcg - a unit of measure for mass) per actuation (act - when you cause the inhaler to spray the medicine plus propellant), two sprays in the nostril one time a day for dry or irritated nose due to oxygen use.	F 759	The LNs were in-serviced by the Director of Nursing (DON) on 6/26/24 regarding facility policies for medication error and medication administration; and the importance of administering medications as ordered. LVN 2 was in-serviced on 6/5/24 by the DON. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The Medical Records Director or designee will twice weekly for 3 months for the administration of residents' medications as ordered and will report any findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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F 759	Continued From page 88 -On 5/31/2024, cholecalciferol oral liquid 125 mcg per milliliter (ml - a unit of measure for volume), give 125 mcg via gastrostomy tube one time a day for nutritional support). During a concurrent observation and interview with LVN 2, on 6/5/2024, at 9:41 a.m., outside Resident 249's room, LVN 2 attempted to prepare Resident 249's medications and stated Resident 249 was scheduled to receive cholecalciferol oral liquid 125 mcg per ml via gastrostomy tube and fluticasone propionate nasal suspension 50 mcg per actuation two sprays in the nostril one time a day for dry or irritated nose due to oxygen use. LVN 2 checked the medication cart and stated Resident 249's medications are not in the cart, and she is unable to administer the resident's medication. LVN 2 stated Resident 249's medications will be late to be administered. During an interview with the Assistant Director of Nursing (ADON), on 6/5/2024, at 4:50 p.m., the ADON stated when resident do not get their medication, it is considered an error and the resident would not get the intended effect of the medication. During a review of the facility's policy and procedure (P&P) titled, "Adverse Consequences and Medication Errors," last reviewed 1/15/2024, indicated a medication error is defined as the preparation or administration of drugs which is not in accordance with physician's orders, manufacturers specifications, or accepted professional standards and principles of the professionals providing services. The P&P further indicated examples of medication errors include omission (a drug is ordered but not administered) and wrong time.	F 759		

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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 to three out of five sampled residents (Resident 34, 11, and 5) investigated during review of unnecessary medications by failing to: 1. Rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin (a drug used to control the amount of sugar in the blood) sites of administration for Residents 34 and 5. 2. Rotate subcutaneous Heparin (a substance that slows the formation of blood clots) administration sites for Resident 11. These deficient practices had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (a rare disease that occurs when a protein called amyloid builds up in organs). Findings: a. A review of Resident 34's Admission Record indicated the facility admitted the resident on 3/5/2024 with diagnoses including type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy with hyperglycemia (a condition that happens	F 760	F760 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. Resident 34 discharged from the facility 06/22/2024. 2. Resident 5 was assessed for site rotation of subcutaneous (SC) insulin administration and the physician notified by the Licensed Nurse (LN) on 6/6/24. 3. Resident 11 was assessed for any adverse effects of SC heparin administration and the physician notified by the LN on 6/15/24. How the facility identified other residents having the potential to be affected by the deficient practice: Current residents that were prescribed SC insulin and heparin were reviewed by the LN on 6/15/24. No other residents were affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The Director of Nursing (DON) in-serviced the LNs on 6/15/24 and 6/18/24 regarding the policy for administering SC insulin and heparin; and the importance of rotating the SC administration sites in order to prevent any adverse effects.	

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F 760	Continued From page 90 when there's too much sugar in the blood). A review of Resident 34's History and Physical (H&P) dated 3/6/2024, indicated the resident was able to make her needs known but did not have the capacity to make decisions. A review of Resident 34's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/8/2024 indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required set -up or clean up assistance with eating and oral hygiene; partial/moderate assistance with personal hygiene and bed mobility; totally dependent on staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 34 received insulin injections. A review of Resident 34's Order Summary Report indicated the following: - Humalog KwikPen SQ solution pen injector 100 unit per milliliter (unit/ml - a unit of measurement (insulin lispro - a short-acting, manmade version of human insulin) inject as per sliding scale: if 71-149 = 0, less than 70 = give orange juice or glucagon call physician; 150-200 = 2; 201-250 = 4; 251-300 = 7; 301-350 = 7; 301-350 = 10; 351-400 = 12, more than 400 give 14, call physician, SQ before meals and at bedtime for diabetes. - insulin glargine solution (a form of hormone insulin made in the laboratory used to control the amount of sugar in the blood of patients with diabetes) 100 unit/ml inject 14 units SQ one time a day for diabetes.	F 760	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The Medical Records Director or designee will audit weekly for 3 months the rotation of SC insulin and heparin administration sites on the medication administration record and report the findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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- Insulin glargine solution 100 unit/ml inject seven (7) unit SQ at bedtime for diabetes.

A review of Resident 34's care plan on risk for hypoglycemia (low blood sugar) and hyperglycemia related to diabetes initiated on 3/13/2024 with target date 6/4/2024 indicated to administer prescribed insulin as ordered.

A review of Resident 34's Location of Administration Report for insulin from 5/2024 to 6/2024 indicated the following:

-Humalog KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML was administered on:
05/11/24 06:30 05/11/24 06:24 subcutaneously Abdomen - Right Lower Quadrant - RLQ
05/11/24 11:30 05/11/24 11:57 subcutaneously Abdomen - RLQ
05/16/24 06:30 05/16/24 06:50 subcutaneously Abdomen - RLQ
05/16/24 06:30 05/16/24 06:50 subcutaneously Abdomen - RLQ
05/16/24 11:30 05/16/24 11:20 subcutaneously Abdomen - RLQ
05/18/24 06:30 05/18/24 06:39 subcutaneously Abdomen - RLQ
05/18/24 11:30 05/18/24 11:05 subcutaneously Abdomen - RLQ
05/22/24 06:30 05/22/24 07:14 subcutaneously Abdomen - Left Upper Quadrant - LUQ
05/22/24 11:30 05/22/24 11:50 subcutaneously Abdomen - LUQ
05/28/24 06:30 05/28/24 06:47 subcutaneously Abdomen - RLQ
05/28/24 11:30 05/28/24 12:53 subcutaneously Abdomen - RLQ
06/02/24 06:30 06/02/24 06:25 subcutaneously

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F 760	Continued From page 92 Abdomen - Right Upper Quadrant (Abdomen - RUQ) 06/02/24 11:30 06/02/24 12:04 subcutaneously Abdomen - RUQ 06/04/24 11:30 06/04/24 11:29 subcutaneously Abdomen - Left Lower Quadrant (LLQ) 06/05/24 11:30 06/05/24 12:15 subcutaneously Abdomen - LLQ -Insulin Glargine Solution 100 UNIT/ML was administered on: 05/07/24 21:00 05/07/24 21:21 subcutaneously Abdomen - RLQ 05/11/24 21:00 05/11/24 22:50 subcutaneously Abdomen - RLQ 05/22/24 21:00 05/22/24 21:25 subcutaneously Abdomen - RLQ During a concurrent interview and record review on 6/05/24 at 4:30 p.m., reviewed Resident 34's Humalog and Insulin Glargine Location of Administration Sites in the Medication Administration Record (MAR) for the month of 5/2024 and 6/2024 with the Assistant Director of Nursing (ADON). The ADON verified the administration sites for the Humalog and Insulin Glargine were not rotated. The ADON stated the administration sites should have been rotated to prevent bruising, bleeding, and irritation on the site which may lead to poor absorption of the medication and the resident not getting the required amount of insulin. A review of the insulin glargine patient package insert provided by the facility, dated 2023, indicated to change (rotate) injection sites within the area chosen with each dose to reduce the risk of getting lipodystrophy and localized cutaneous amyloidosis (skin with lumps). The package insert	F 760		

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further indicated to not use the exact same spot for each injection, not inject where the skin has pits, is thickened, or has lumps, where the skin in tender, bruised, scaly or hard, scars, or damaged skin.

A review of the Humalog manufacturer's guidelines provided by the facility last revised 8/2023, indicated to rotate the injection site within the same to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

A review of the facility's policy and procedure (P&P) titled, "Adverse Consequences and Medication Errors," last reviewed 1/15/2024, indicated a medication error is defined as the preparation or administration of drugs which is not in accordance with the physician's order, manufacturer specification, or accepted professional standards and principles of the professionals providing services.

b. A review of Resident 5's Admission Record indicated the facility admitted Resident 5 on 1/25/2021 with diagnoses including, but not limited to, type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and transient cerebral ischemic attack (a brief episode of neurological [relating to the brain] dysfunction resulting from an interruption in the blood supply to the brain or the eye).

A review of Resident 5's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/13/2024, indicated Resident 5 had moderate cognitive impairment (difficulty understanding and making decisions), required supervision with eating, and required maximal

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assistance or was dependent on facility staff for other activities of daily living, including hygiene, toileting, and surface to surface transfers. The MDS further indicated Resident 5 was at risk for pressure ulcers and received treatments, including pressure reducing device for the bed.

A review of Resident 5's Order Summary Report indicated Resident 5 was ordered the following:
- On 7/4/2023, Insulin Glargine Solution (a type of insulin) 100 units (a unit of measure) per milliliter (ml - a unit of measure for volume) inject 10 units subcutaneously at bedtime for diabetes.
- On 9/18/2023, Insulin Aspart (also known as NovoLog Solution, a type of insulin) inject subcutaneously two times a day for type two diabetes.

A review of Resident 5's Medication Administration Record (MAR), dated 5/2024, indicated Resident 5 was administered the following:
- On 5/4/2024, at 6:39 a.m., NovoLog Solution subcutaneously in the left lower quadrant (LLQ) of the abdomen (area around the stomach).
- On 5/4/2024, at 8:25 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 5/4/2024, at 8:26 p.m., insulin glargine subcutaneously in the LLQ of the abdomen.
- On 5/6/2024, at 8:35 p.m., NovoLog Solution subcutaneously in the right lower quadrant (RLQ) of the abdomen.
- On 5/7/2024, at 6:35 a.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/7/2024, at 9:08 p.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/9/2024, at 9:19 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/10/2024, at 8:19 p.m., insulin glargine

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subcutaneously in the RLQ of the abdomen.
- On 5/13/2024, at 5:39 a.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/13/2024, at 8:53 p.m., NovoLog Solution subcutaneously in the RLQ of the abdomen.
- On 5/13/2024, at 8:56 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/14/2024, at 9:13 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/15/2024, at 8:56 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/16/2024, at 5:49 a.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 5/16/2024, at 9:23 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 5/19/2024, at 8:22 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/20/2024, at 10:27 p.m., insulin glargine subcutaneously in the RLQ of the abdomen.
- On 5/21/2024, at 6:47 a.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 5/21/2024, at 8:33 a.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.

A review of Resident 5's MAR, dated 6/2024, indicated Resident 5 was administered the following:
- On 6/1/2024, at 8:43 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 6/1/2024, at 8:54 p.m., insulin glargine subcutaneously in the LLQ of the abdomen.
- On 6/2/2024, at 9:05 p.m., NovoLog Solution subcutaneously in the LLQ of the abdomen.
- On 6/2/2024, at 9:12 p.m., insulin glargine

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subcutaneously in the LLQ of the abdomen.

During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 4:50 p.m., Resident 5's MAR, dated 5/2024 and 6/2024, was reviewed and the ADON confirmed there were entries in the MAR indicating the injection sites were not rotated. The ADON further stated insulin injections sites should be rotated and not be injected in the same site because it can potentially lead to bruising, bleeding, and or lipodystrophy.

A review of the insulin glargine patient package insert provided by the facility, dated 2023, indicated to change (rotate) injection sites within the area chosen with each dose to reduce the risk of getting lipodystrophy and localized cutaneous amyloidosis. The package insert further indicated to not use the exact same spot for each injection, not inject where the skin has pits, is thickened, or has lumps, where the skin in tender, bruised, scaly or hard, scars, or damaged skin.

A review of the NovoLog package insert provided by the facility, last revised 2/2023, indicated to rotate the injection site within the same region from one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis.

A review of the facility's policy and procedure (P&P) titled, "Adverse Consequences and Medication Errors," last reviewed 1/15/2024, indicated a medication error is defined as the preparation or administration of drugs which is not in accordance with the physician's order, manufacturer specification, or accepted professional standards and principles of the

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professionals providing services.

c. A review of Resident 11's Admission Record indicated the facility admitted the resident on 4/5/2024, with diagnoses including atrial fibrillation (an irregular and often very rapid heart rhythm), heart failure (occurs when the heart muscle does not pump blood as well as it should), and gastritis (inflammation of the lining of the stomach).

A review of Resident 11's History and Physical (H&P), dated 4/8/2024, indicated the resident was receiving heparin every 8 hours for deep vein thrombosis (DVT, a blood clot that develops within a deep vein in the body, usually in the leg) prophylaxis (PPX, preventive). The H&P also indicated the resident had the capacity to make needs known but unable to make medical decisions.

A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/8/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had moderately impaired cognition (a range of mental processes relating to the acquisition, storage, manipulation, and retrieval of information) and was on a high drug class medications anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the hear) and antiplatelet drugs (a group of medicines that stop blood cells [called platelets] from sticking together and forming a blood clot).

A review of Resident 11's Order Summary Report, on 5/6/2024, indicated an order for heparin

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F 760	Continued From page 98 sodium (Porcine) injection solution 500 unit (an amount approximately equivalent to 0.002 mg of pure heparin)/milliliters (ml, a unit of volume). Inject 1 cubic centimeter (cc, a unit of volume) subcutaneously every 8 hours for DVT PPX. Rotate sites of injection. A review of Resident 11's Location of Administration Report for the months of 4/2024 to 5/20204, indicated heparin was administered on: 4/9/24 at 6:34 a.m. on the Abdomen - Right Lower Quadrant (RLQ) 4/9/24 at 1:45 p.m. on the Abdomen - RLQ 4/9/24 at 9:28 p.m. on the Abdomen - RLQ 4/10/24 at 5:25 a.m. on the Abdomen - RLQ 4/10/24 at 2:08 p.m. on the Abdomen - RLQ 4/11/24 at 5:15 a.m. on the Abdomen - Right Upper Quadrant (RUQ) 4/11/24 at 2:01 p.m. on the Abdomen - RUQ 4/11/24 at 9:54 p.m. on the Abdomen - RUQ 4/12/24 at 5:59 a.m. on the Abdomen - RLQ 4/12/24 at 1:05 p.m. on the Abdomen - RLQ 4/13/24 at 6:15 a.m. on the Abdomen - RLQ 4/13/24 at 2:12 p.m. on the Abdomen - RLQ 4/19/24 at 6:03 p.m. on the Abdomen - RLQ 4/19/24 at 9:36 a.m. on the Abdomen - RLQ 4/20/24 at 9:05 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 4/21/24 at 6:51 a.m. on the Abdomen - LLQ 4/27/24 at 5:35 a.m. on the Abdomen - RLQ 4/27/24 at 2:43 p.m. on the Abdomen - RLQ During a concurrent interview and record review on 6/5/2024, at 10:24 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 11's Order Summary Report, including the discontinued orders, the Location of Administration site of heparin injection for the	F 760		

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month of 4/2024 to 5/2024. The ADON stated there were multiple repeated sites of heparin subcutaneous administration between 4/2024 to 5/2024. The ADON stated the sites of heparin administration should be rotated to prevent bleeding, bruising, and irritation on the frequently administered sites. The ADON added the failure to rotate insulin administration sites per physician's order and not following the manufacturer's guidelines for heparin use is considered a medication error.

A review of the facility's recent policy and procedure titled, "Adverse Consequences and Medication Errors," last reviewed 1/15/2024, indicated a "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.

A review of the facility's recent policy and procedure titled, "Medication and Treatment Orders," last reviewed on 1/15/2024, indicated orders for medications and treatment will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.

A review of the facility provided manufacturer's guideline on the use of Heparin, with U.S. initial approval in 1939, indicated, to use a different site for each injection. Hemorrhage, including fatal events, has occurred in patients receiving heparin. Use caution in conditions with increased risk of hemorrhage. Monitor for signs and

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F 760	Continued From page 100 symptoms and discontinue if indicative of HIT and HITTS. Most common adverse reactions are hemorrhage, thrombocytopenia, HIT and HITTS, injection site irritation, general sensitivity reactions, and elevations of aminotransferase levels.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure safe provision	F 761	F761 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: The five unlabeled albuterol nebules were discarded by the Licensed Nurse (LN) on 06/04/2024. How the facility identified other residents having the potential to be affected by the deficient practice: The medication carts were reviewed for any unlabeled medications by the LN on 6/4/24. No other issues were identified. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The LNs were in-serviced on 6/19/24 by the Director of Nursing (DON) regarding the facility policy for medication storage and the importance of labeling medications.	

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F 761	Continued From page 101 of pharmaceutical services during the inspection of one of one medication carts (Medication Cart 2) reviewed during the Medication Storage and Labeling task by failing to ensure five unpackaged and unlabeled albuterol (a medication that relaxes muscles in the airways and increases air flow to the lungs) nebules (a plastic container that holds liquid medication) were not stored and readily available for use in Medication Cart 2. This deficient practice had the potential to result in medication being administered to the wrong resident or loss of resident medication. Findings: During a concurrent medication storage observation and interview on 6/4/2024 at 4:13 p.m. with Licensed Vocational Nurse 2 (LVN 2) at Medication Cart 2, observed five unpackaged and unlabeled albuterol nebules in the bottom, right drawer of the medication cart. LVN 2 stated the five albuterol nebules in the drawer were not in a labeled box, not labeled to identify the resident to whom they belonged, and not labeled with an opened date. LVN 2 stated each resident receiving inhalation treatments has their own labeled box that contains the resident's nebules in a foil pouch. LVN 2 stated she did not know who the unlabeled nebules belonged to. LVN 2 stated the nebules should have been thrown away and not stored in the cart. LVN 2 stated the unlabeled nebules could possibly have been used for a resident past the expiration date resulting in the medication possibly not working. LVN 2 stated medications should be labeled to ensure they are not used on multiple residents.	F 761	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The ADON or designee will audit the medication storage areas weekly for 3 months to ensure medications are labeled. Any issues identified will be corrected and reported to the DON. The DON will report finding or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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F 761	Continued From page 102 During a concurrent interview and record review on 6/5/2024 at 9:37 a.m., the Director of Nursing (DON) reviewed the facility policy and procedure regarding medication storage. The DON stated the proper storage process for nebules is they are kept enclosed in the foil packet and labeled when opened. The DON stated if any nebules are in the cart and not in a labeled box, then the nebules should be disposed of but they were not. The DON stated the importance of removing and disposing of unlabeled medications is that it is not possible to determine where the medication came from or to which resident it belonged to. The DON stated it was important for resident safety for nurses to monitor the labeling of medications, so the wrong medication is not given to a resident resulting in medication errors. The DON stated the facility policy and procedure was not followed because medications are supposed to be in the correct labeled container and the nebules were not. A review of the facility provided policy and procedure titled, "Storage of Medications," last reviewed 1/15/2024, indicated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medication between containers. The nursing staff shall be responsible for maintaining medication storage. Drug containers that have missing labels shall be returned to the pharmacy for proper labeling for storing. Drugs shall be stored in an orderly manner. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several	F 761		

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F 761	Continued From page 103 residents.	F 761		
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 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: 1. The staff followed the dress code in the kitchen 2. Food was labeled with a date, stored correctly, and disposed of when contaminated. 3. Kitchen equipment and utensils were kept clean. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead	F 812	F812 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. Inservice was conducted with Dishwasher 1 and kitchen staff by the Dietary Manager on 6/10/24 regarding the dress code as it relates to wearing jewelry. 2. Food items stored in the walk-in refrigerator and kitchen without proper dates or noted spoiled were immediately discarded; food items improperly stacked/ stored unsafely were stacked and stored properly and not to impede the 18-inch rule; and staff personal food/drink items were removed from the kitchen by the DM on 06/04/2024. 3. The oven, hood, stove, fryer, steam table and floors were deep cleaned by the maintenance staff on 06/04/2024. How the facility identified other residents having the potential to be affected by the deficient practice: Residents who are served food from the kitchen have the potential to be affected by the deficient practice. No other residents were affected by the deficient practice.	

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F 812	Continued From page 104 to foodborne illness (an illness caused by food contaminated with bacteria, viruses, and other toxins) in 42 of 44 medically compromised and vulnerable residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview on 6/4/2024 at 8:10 a.m., with Dietary Aide (DA) 2 in the kitchen, DA 2 was preparing the drinks and shared open condiments of strawberry preserve, lemons, and drinks for the resident's meal trays. DA 2 was wearing a long dangling necklace and watch that was not covered to avoid exposure to food. DA 2 stated she was never advised that she could not wear jewelry while handling food. During a concurrent observation and interview on 6/4/2024 at 8:39 a.m. with Dishwasher (DW) 1in the dishwashing area, DW 1 was sanitizing then drying dishes on a tall dish drying rack with several shelves. DW1 was wearing two long, dangling necklaces, earrings, and a bracelet that was not covered to avoid exposure the sanitized dishes. DW 1 stated she does not remember if the dress code allowed for kitchen staff to wear jewelry. During an interview on 6/4/2024 at 11:37 with Dietary Manager (DM), DM stated it is against the facility's policy for the kitchen staff to wear dangling jewelry in the kitchen. DM further stated the kitchen staff were not allowed to wear jewelry due to infection control and cross-contamination as jewelry could potentially touch or fall into the food. A review of the facility's Policies and Procedures	F 812	Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: 1. Dietary staff were in-serviced by the DM on 6/10/24 regarding the facility policy related to dress code, especially wearing jewelry. 2. Dietary staff were in-serviced by the DM on 6/4/24 and 6/10/24 regarding facility policy and the importance of properly storing and labeling food items, and no eating or drinking by staff in the kitchen area to prevent cross contamination and/or potential food borne illness. 3. The DM in-serviced the dietary and maintenance staff on 6/4/24 and 6/17/24 regarding the facility policy and the importance of keeping the facility clean, without any grease build-up or dirt debris in the oven, hood, stove, fryer, steam table or floors. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system:	

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F 812	Continued From page 105 (P&P - the rules that staff abide by as they carry out their various responsibilities) titled "Dress Code," dated 1/15/2024, it indicated, "Proper Dress: No excessive jewelry, just wedding rings on hand, non-dangling earrings on ears and wristwatch. Wristwatch and wedding rings need to be covered with gloves when handling food." A review of "Food Code 2017" indicated, "2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands." 2. During a concurrent observation and interview on 6/4/2024 at 8:15 a.m. with DA 1, in the walk-in refrigerator and kitchen, the following foods were not labeled with an open date or use by date: " Two containers of opened garlic spread were unlabeled. " Two containers of opened strawberry spread were unlabeled. " Three containers of opened peeled garlic, with condensation, were unlabeled. " Two containers of opened syrup were unlabeled. " One container of opened soy sauce was unlabeled. " One container of maraschino cherries, unlabeled. " One unlabeled zip-loc bag of diced chicken. " One unlabeled zip-loc bag of celery and carrots. " One unlabeled bowl of sliced lemons. " One uncovered and undated large pan of peeled carrots. " One uncovered and undated box of bacon inside the walk-in refrigerator.	F 812	The DM or designee will conduct 3 times per week kitchen rounds for 3 months and on-going to ensure that staff are following the dress code, labeling food items per policy, no staff eating or drinking in kitchen areas and the kitchen appliances and floors are maintained with no grease build-up or dirt debris. Any issues identified will be corrected. The DM will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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DA1 stated when any food items are opened, prepped, or stored as leftovers, they must have an open/prepared date and a use by date as bacteria could grow if it was stored longer than recommended and if food product remained unused.

During a concurrent observation and interview on 6/4/2024 at 8:20 a.m. with Cooking Assistant (CA), in the walk-in refrigerator, one container of blueberries had a black or grey furry substance appearing like mold (a soft, green, or gray growth that develops on old food or on objects that have been left for too long in warm, wet air) on several berries. CA stated moldy fruit cannot be served to residents as it could cause a foodborne illness.

During concurrent observation and interview on 6/4/2024 at 8:22 a.m. with CA in the walk-in refrigerator, five produce boxes in one stack and four produce boxes in a second stack containing cucumbers, lettuce, tomatoes, and broccoli were stacked to the ceiling on the top shelf. One large watermelon was stacked on top of an open box of lettuce and a container of cucumbers, and a container of tomatoes was stacked on top of whole watermelon and cantaloupes. CA stated stacking items to the ceiling is very unsafe as they can fall and hurt someone. CA stated the boxes must be taken down and there needs to be a space of 18 inches from the food items and the ceiling. CA further stated stacking heavy fruit, such as a watermelon, on top of other produce, the weight of the watermelon can damage the other produce.

During an observation on 6/4/2024 at 8:30 a.m. in the prep area of the kitchen, there was an opened bag of potato chips next to food for the residents.

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During an interview on 6/4/2024 at 8:31 a.m. with CA, CA stated the opened bag of chips belonged to the Assisted Living Chef (CH) and witnessed CH eating them recently.

During an interview on 6/4/2024 at 8:34 a.m. with CH, CH admitted to eating the potato chips in the food prep area. CH further stated he was hungry, and it is not his practice to eat in the food prep area as it unsanitary and could result in cross contamination.

During an observation on 6/4/2024 at 8:38 a.m. in the dishwashing area of the kitchen, the tall clean dish air dry rack had a cup of soda, coffee cup, a plastic cup with food debris and a spoon inside and a napkin with crumbs in it was next to clean dishes.

During an interview on 6/4/2024 at 8:40 a.m. with DW 1, DW 1 stated the coffee cup, plastic cup of food with spoon and napkin with crumbs belonged to her. DW 1 stated staff should not eat or drink in any area of the kitchen, including near the clean dishes because it can un-sanitize them.

During an interview on 6/4/2024 at 8:42 a.m. with DW 2, DW 2 stated the cup of soda belonged to him and drinking or storing an open cup of soda near clean dishes can make them dirty which is not safe for the residents.

During an interview on 6/4/2024 at 11:37 a.m. with DM, DM stated their process of labeling and dating food in the kitchen included labeling food with delivery date, use-by-date, and date food was opened. DM stated prepared foods had 72 hours shelf-life. DM stated it was important to

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label and date food to prevent serving food to residents that would cause food borne illness, to keep residents safe and prevent from keeping/storing potentially spoiled food. DM further stated kitchen staff may never eat personal food in any part of the kitchen and there is a breakroom provided for staff to eat while on breaks. DM stated eating in the kitchen around resident's food can cause cross contamination and food borne illness.

A review of the facility's P&P, reviewed on 1/15/2024 titled, "Labeling and dating of foods," it indicated, "AII food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines. Leftovers will be covered, labeled, and dated."

A review of "Food Code 2017" 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 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

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use-by date based on food safety."

3. During a concurrent observation and interview on 6/4/2024 at 8:47 a.m. with DA 1 in the kitchen, the oven, hood, stove, fryer, steam table and floors had grease, dirt, and debris build-up; inside and out. DA 1 stated the cooking equipment should be cleaned after each use or at least daily. DA 1 further stated the maintenance department is supposed to clean the hood weekly.

During a concurrent observation and interview on 6/4/2024 at 8:50 a.m. with CA in the kitchen, the cutting boards were stacked next to each other vertically while still wet. CA stated putting away the cutting boards while still wet can produce bacteria and mold.

During an interview on 6/4/2024 at 11:55 a.m. with DM, DM stated the kitchen at that time had built up dirt and grease and would address it immediately. DM stated it is not sanitary to have dirt and grease built up in the kitchen as it can cause foodborne illnesses and cross contamination.

During an interview on 6/5/2024 with Administrator (ADM), ADM was shown photographs of findings from the initial walk-through of the kitchen on 6/4/2024. ADM stated the cleanliness of the kitchen was unacceptable.

A review of the facility's P&P titled, "Ranges and Ovens," reviewed on 1/15/2024, it indicated, "Grills must be cleaned after each use. Allow sufficient time for grills to cool before cleaning. Back apron of the range and other range surfaces should be washed with a hot detergent

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F 812	Continued From page 110 solution following manufacturer's instructions to remove grease. Always empty and wash the grease catch pan after each use. Weekly, and as often as necessary, racks and shelves should be removed and cleaned in a warm detergent solution following manufacturer's instructions. Hoods must be cleaned every two weeks and must be free of dust and grease." A review of the facility's P&P titled "General Cleaning of Food and Nutrition Services Department," reviewed on 1/15/2024, it indicated, "Floors must be mopped at least once per day. Sweep the floor, pushing all debris forward. Use a dustpan to remove and dispose of debris as it accumulates.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	F842 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: Resident 249 was assessed and the physician was notified of the missed medication by the Licensed Nurse (LN) on6/5/24. 1:1 coach and counseling was conducted with LVN 2 by the Director of Nursing (DON) on 06/05/2024. How the facility identified other residents having the potential to be affected by the deficient practice: Medication administration records for the first week of June 2024 were reviewed by the LN on 6/5/24. No other issues were identified.	

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F 842	Continued From page 111 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842	Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The LNs were in-serviced by the DON on 6/18/24 and 6/26/24 regarding the facility policies for medication administration and charting, and the importance of not signing a medication as given if it was not administered. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The ADON or designee will conduct medication administration chart code audit for LNs weekly at random across all 3 shifts for 3 months to ensure medications are administered and documented correctly or if they had not been administered and report any findings to the DON. Any issues identified will be corrected. The DON will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to maintain clinical records that are complete and accurate for one of seven sampled residents investigated during medication administration (Resident 249) by documenting the administration of cholecalciferol (a medication used to supplement Vitamin D [a nutrient the body needs for building and maintaining healthy bones]) when it was not administered.

This deficient practice resulted in inaccurate documentation in Resident 249's medical record.

Findings:

A review of Resident 249's Admission Record indicated the facility admitted the resident on 5/31/2024 with diagnoses including gastrostomy status (creation of an artificial external opening into the stomach for nutritional support) and retention of urine.

A review of Resident 249's Order Summary Report, dated 5/31/2024, indicated a physician's order for cholecalciferol oral liquid 125 mcg (micrograms - a unit of measure for mass) per milliliter (ml - a unit of measure for volume), give 125 mcg via gastrostomy tube one time a day for nutritional support.

During a concurrent interview and record review

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F 842	Continued From page 113 with Licensed Vocational Nurse 2 (LVN) 2, on 6/5/2024 at 2:57 p.m., Resident 249's MAR dated 6/4/2024 was reviewed. LVN 2 stated she documented Resident 249's cholecalciferol oral liquid 125 mcg per ml was administered. LVN 2 stated she did not have the medications to administer to the resident on 6/4/2024. LVN 2 stated she accidentally marked the medication as administered and apologized for marking it as administered. During an interview with the Assistant Director of Nursing (ADON), on 6/5/2024, at 4:50 p.m., the ADON stated it is not appropriate to document medications as administered in the MAR when it was not administered to the resident because it can potentially cause problems from not receiving the medications for the resident. The ADON stated the MAR aids in communicating with the other nurses so they would know that medications were administered properly. The ADON further stated when nurses document medications in the MAR, they are aware of what they are documenting. A review of the facility's policy and procedure (P&P) titled, "Administering Medications," last reviewed 1/15/2024, indicated medications are administered in a safe and timely manner, and as prescribed. The P&P further indicated the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.	F 842		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements	F 847	F847	

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F 847	Continued From page 114 If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain	F 847	F847 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. The Admission Director reviewed the Arbitration Agreement with Resident 246's family member on 5/13/24 and 6/12/24. 2. The Admission Director reviewed the Arbitration Agreement with Resident 4 on 5/2/24. 3. Resident 40 discharged from the facility 06/20/2024. How the facility identified other residents having the potential to be affected by the deficient practice: Residents who are admitted to the facility have the potential to be affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: The Administrator in-serviced the Admission Director on 6/18/24 and 6/26/24 regarding the Arbitration Agreement process.	

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F 847	Continued From page 115 any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the arbitration (a private process where disputing parties agree that one or several other individuals can make a decision about the dispute after receiving evidence and hearing arguments) agreement (a written contract in which two or more parties agree to settle a dispute out of court) was explained to residents in a form and manner that the resident understands, and the the resident and/or representative acknowledged that they understand the agreement to two of three sampled residents reviewed under the Arbitration care area (Resident 4 and 246) when: a. Resident 246's representative Family Member 1 (FM1), signed the facility's arbitration agreement without knowing the agreement can be rescinded by written notice within 30 days. b. Residents 4 and 40 signed the facility's arbitration agreement without understanding what they signed and without knowing the agreement can be rescinded by written notice within 30 days. These deficient practices resulted in the residents not knowing or understanding what an arbitration agreement is and potentially cause feelings of doubt, confusion, or distress.	F 847	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: The Administrator or designee will conduct 2 random reviews of arbitration documentation completion and disclosure from admissions, weekly for 2 months with admission director, residents and/or their resident representative to ensure they have been communicated and acknowledge arbitration with 30-day option to rescind. Any issues identified will be corrected. The Administrator will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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Findings:

a. A review of Resident 246's Admission Record indicated the facility admitted the resident on 5/2/2024 with diagnoses including type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy with hyperglycemia [a condition that happens when there's too much sugar in the blood]).

A review of Resident 246's History and Physical (H&P) dated 5/5/2024, indicated the resident had the capacity to understand and make decisions.

A review of Resident 246's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/5/2024 indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required set -up or clean up assistance with eating and oral hygiene; partial/moderate assistance with personal hygiene; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).

A review of Resident 246's Arbitration Agreement, dated 5/13/2024, indicated Resident 246's FM 1 signed her name acknowledging that the facility is relying on this representation and that any claims that she may assert in her capacity related to any failure of provision of services or goods by the facility to the resident or the admission agreement are governed by the arbitration agreement.

During an interview on 6/4/2024 at 4:30 p.m., FM 1 stated that she signed the admission

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agreement including the arbitration agreement and did not fully understand what it was about and that she was not aware the agreement can be rescinded within 30 days. FM 1 stated she was just told she can or cannot sign the agreement and was not a condition for Resident 246's admission.

During an interview on 6/5/2024 at 11:17 a.m., the Admissions Director (AD) stated the arbitration agreement is part of the admission packet and signed electronically thru a tablet. The AD stated he explains to the resident or their representative the arbitration agreement is not a condition for admission to the facility and they do not have to sign it. The AD stated he did not explain to the resident or their representative the agreement can be rescinded by written notice within 30 days. The AD stated he will further explain the arbitration agreement if they have any questions. The AD stated it is important for the residents and/or their representatives to know the agreement can be rescinded if they decide to take legal action and do not want a second party representative to resolve issues.

During an interview on 6/5/2024 at 4:00 p.m., the Assistant Director of Nursing (ADON) stated the arbitration agreement is important for residents and/or their representatives to understand what they are signing for, so they will be confused.

A review of the facility's policy and procedure titled, "Resident Rights: Arbitration Agreement," last reviewed 1/15/2024, indicated the AD shall clearly explain that the resident or his or her representative has 30 calendar days to withdraw from or terminate the agreement, should he or she change their mind to ensure they have time

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to reconsider the decision to use arbitration to settle a dispute with the facility.

b. A review of Resident 4's Admission Record indicated the facility admitted the resident on 4/24/2024 with diagnoses including type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar and using it for energy with hyperglycemia [a condition that happens when there's too much sugar in the blood]), and lack of coordination.

A review of Resident 4's History and Physical (H&P) dated 4/25/2024, indicated the resident had the capacity to understand and make decisions.

A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/27/2024 indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required set -up or clean up assistance with eating; partial/moderate assistance with oral and personal hygiene; substantial/maximal assistance with toileting; dependent on staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).

A review of Resident 4's Arbitration Agreement, dated 5/13/2024, indicated Resident 4 signed her name under the section indicating, "Notice: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article One (1) of this contract." The agreement indicated under Article

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F 847	Continued From page 119 IV Section 6.1: This agreement may be rescinded by written notice within 30 days of signature. During an interview on 6/4/2024 at 11:00 a.m., Resident 4 acknowledged that she signed the admission papers including the arbitration agreement but did not fully understand the content or what the arbitration agreement was about. Resident 4 stated she was unable to remember if she signed via a tablet or paper form. Resident 4 was unable to verbalize the arbitration process. During an interview on 6/5/2024 at 11:17 a.m., the Admissions Director (AD) stated the arbitration agreement is part of the admission packet and signed electronically through a tablet. The AD stated he explains to the resident or their representative the arbitration agreement is not a condition for admission to the facility and they do not have to sign it. The AD stated he did not explain to the resident or their representative the agreement can be rescinded by written notice within 30 days. The AD stated he will further explain the arbitration agreement if they have any questions. The AD stated it is important for the residents and/or their representatives to know the agreement can be rescinded if they decide to take legal action and do not want a second party representative to resolve issues. During an interview on 6/5/2024 at 4:00 p.m., the Assistant Director of Nursing (ADON) stated it is important for residents and their representative to understand the arbitration agreement before signing it to prevent confusion. A review of the facility's policy and procedure titled, "Resident Rights: Arbitration Agreement,"	F 847		

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last reviewed 1/15/2024, indicated the AD shall clearly explain that the resident or his or her representative has 30 calendar days to withdraw from or terminate the agreement, should he or she change their mind to ensure they have time to reconsider the decision to use arbitration to settle a dispute with the facility.

c. A review of Resident 40's Admission Record indicated the facility admitted the resident on 5/9c/2024 with diagnoses including basal cell carcinoma of skin (a type of skin cancer that most often develops on areas of skin exposed to the sun, such as the face), and anxiety disorder (a disorder that involves persistent and excessive worry that interferes with daily activities).

A review of Resident 40's History and Physical (H&P) dated 5/12/2024, indicated the resident had the capacity to understand and make decisions.

A review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/12/2024 indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; partial/moderate assistance with oral and personal hygiene; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive).

A review of Resident 40's Arbitration Agreement, dated 5/28/2024, indicated Resident 40 signed his name under the section indicating, "Notice: By signing this contract you are agreeing to have any

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issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article One (1) of this contract." The agreement indicated under Article IV Section 6.1: This agreement may be rescinded by written notice within 30 days of signature.

During an interview on 6/4/2024 at 11:05 a.m., Resident 40 acknowledged that he signed the admission papers including the arbitration agreement but did not fully understand the content or what the arbitration agreement was about. Resident 4 stated he was unable to remember if he signed via a tablet or paper form. Resident 40 was unable to verbalize the arbitration process.

During an interview on 6/5/2024 at 11:17 a.m., the Admissions Director (AD) stated the arbitration agreement is part of the admission packet and signed electronically thru a tablet. The AD stated he explains to the resident or their representative the arbitration agreement is not a condition for admission to the facility and they do not have to sign it. The AD stated he did not explain to the resident or their representative the agreement can be rescinded by written notice within 30 days. The AD stated he will further explain the arbitration agreement if they have any questions. The AD stated it is important for the residents and/or their representatives to know the agreement can be rescinded if they decide to take legal action and do not want a second party representative to resolve issues.

During an interview on 6/5/2024 at 4:00 p.m., the Assistant Director of Nursing (ADON) stated it is important for residents and their representative to understand the arbitration agreement before

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F 847	Continued From page 122 signing it to prevent confusion. A review of the facility's policy and procedure titled, "Resident Rights: Arbitration Agreement," last reviewed 1/15/2024, indicated the AD shall clearly explain that the resident or his or her representative has 30 calendar days to withdraw from or terminate the agreement, should he or she change their mind to ensure they have time to reconsider the decision to use arbitration to settle a dispute with the facility.	F 847		
F 880 SS=E	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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880	F880 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 1. All Nursing Staff were in-serviced by the Infection Preventionist (IP) on 6/10/24 regarding cleaning and disinfecting the blood pressure (BP) cuff between resident use. 2. All Nursing Staff were in-serviced by the IP on 6/5/24 and 6/10/24 regarding the facility policy and the importance of enhanced barrier precautions (EBP) for residents, especially for Resident 249. 3. Resident 20 discharged from the facility on 06/11/2024. 4. The nursing staff were in-serviced by the IP on 6/10/24 and 6/22/24 regarding mechanical lift slings are assigned to resident and cleaned if soiled and/or after finished with use. Sling will be laundered before using with another patient. 5. The oxygen (O2) tubing was changed for Residents 13 and 37 on 06/04/2024.	

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F 880	Continued From page 123 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. The facility will conduct an annual review of its	F 880	How the facility identified other residents having the potential to be affected by the deficient practice: Residents who need to have their BP monitored, require EBP, use a BiPAP machine, use a mechanical lift and use O2 therapy have the potential for be affected by the deficient practice. Measures put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur: 1. All Nursing Staff were in-serviced by IP on 6/10/24 regarding cleaning and disinfecting the blood pressure (BP) cuff between resident use. No other residents were affected by the deficient practice. 2. All Nursing Staff were in-serviced by the IP on 6/5/24 and 6/10/24 regarding the facility policy and the importance of enhanced barrier precautions (EBP) for residents, especially for Resident 249. No other residents were affected by the deficient practice.	

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F 880	Continued From page 124 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 to help prevent the development and transmission of communicable diseases and infections by failing to: 1. Ensure Licensed Vocational Nurse 2 (LVN 2) sanitized the reusable blood pressure cuff (a device placed on the arm and used to measure blood pressure [BP, the force of the blood pushing on the blood vessel walls]) before and after use on residents for three of seven sampled residents (Residents 196, 20, and 28) reviewed under the Infection Control task. 2. Ensure LVN 2 put on personal protective equipment (PPE - protective clothing or equipment designed to protect the wearer's body from infection) prior to providing care for one out of seven sampled residents observed during medication administration (Resident 249) under enhanced barrier precautions (EBP - used in conjunction with standard precautions, the expanded used of PPE to donning [to put on] of gown and gloves during high-contact resident care activities and in situations of expected exposure to blood, body fluids, skin breakdown, or mucous membranes that provides opportunities for transfer of multi-drug resistant organisms [MDRO - a germ that is resistant to multiple medications used to treat infection] to staff hands and clothing to reduce transmission). 3. Ensure staff changed the bilevel positive airway pressure (BIPAP, machine that helps a	F 880	3. All Nursing Staff were in-serviced by the IP on 6/10/24 regarding changing BiPAP masks per manufacturer's guidelines. No other residents were affected by the deficient practice. 4. The nursing staff were in-serviced by the IP on 6/10/24 and 6/22/24 regarding mechanical lift slings are assigned to resident and cleaned if soiled and/or after finished with use. Sling will be laundered before using with another patient. No other residents were affected by the deficient practice. 5. The LNs were in-serviced by the IP regarding changing O2 tubing per facility policy on 6/10/24. No other residents were affected by the deficient practice. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring the correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC must be integrated into the quality assurance system: 1. The IP or designee will randomly observe 5 residents' BP being taken weekly for 3 months to ensure the BP cuff is cleaned and disinfected between each resident use.	

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F 880	Continued From page 125 person breathe) machine facemask weekly for one of nine sampled residents reviewed during a random screening (Resident 20). Resident 20's mask was dated 5/17/2024. 4. Ensure mechanical lift slings (sling used for lifting residents using a mechanical lift) were single patient use. The Hoyer lift slings were left hanging on the sling for reuse, instead of bagging the used sling for washing. 5. Label the nasal cannula (NC - tubing connected to a device that gives additional oxygen through the nose) with the date it was last changed for two out of nine sampled residents (Resident 13 and 37) during a random observation. These deficient practices had the potential for cross-contamination and placed the residents at risk for acquiring infections. Cross-reference F726, F755, F759 Findings: 1.a. A review of Resident 196's Admission Record indicated the facility admitted the resident on 4/23/2024 with diagnoses that included fracture (broken bone) of the sacrum (region at the bottom of the spine), hypertension (high blood pressure), immunodeficiency (decreased ability of the body to fight infections and other diseases) and need for assistance with personal care. A review of Resident 196's Minimum Data Set (MDS - an assessment and care screening tool) dated 4/26/2024, indicated the resident usually was able to understand others and usually was	F 880	2. The IP or designee will randomly observe 5 residents' with EBP weekly for 3 months to ensure that PPE is used according to facility policy. 3. The IP or designee will review weekly any resident who uses a BiPAP machine that the mask is changed according to manufacturer's guidelines. If resident arrives with personal device we will offer to use facility provider equipment. 4. The IP or designee will randomly observe 5 residents who use a mechanical lift weekly for 3 months to ensure that the slings are assigned to resident and cleaned if soiled and/or after finished with use. Sling will be laundered before using with another patient. 5. The IP or designee will review all residents on O2 therapy weekly for 3 months to ensure tubing is changed according to facility policy. Any issues identified will be corrected. The IP will monitor for compliance and report any findings or trends to the monthly Quality Assurance Performance Improvement Committee Meeting. Date when corrective actions will be completed: 06/28/2024	

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able to make herself understood. The MDS further indicated the resident required partial assistance with oral hygiene and upper body dressing, maximum assistance with lower body dressing and putting on footwear and was dependent on staff for bathing and toileting.

A review Resident 196's Care Plan (CP) titled, "Resident at Risk for COVID 19 (Coronavirus disease -2019, a highly contagious viral infection that can trigger respiratory tract infection) due to refusal of updated vaccine," initiated 4/23/2024, indicated the resident and resident representative were made aware the resident is at higher risks for severe symptoms due to not being vaccinated.

A review Resident 196's CP titled, "High Risk for Influenza (an infection of the nose, throat and lungs, which are part of the respiratory system) due to refusal of influenza vaccine and being more than 65 years old," initiated 4/23/2024, indicated the resident and resident representative were made aware the resident is at higher risks for severe symptoms due to not being vaccinated and staff would minimize the risk for influenza infection.

A review Resident 196's CP titled, "High Risk for bacterial Pneumonia (an infection of one or both of the lungs) due to refusal of vaccine and being more than 65 years old," initiated 4/23/2024, indicated the resident and resident representative were made aware the resident is at higher risks for severe symptoms due to not being vaccinated and staff would minimize the risk for pneumonia infection.

1.b. A review of Resident 20's Admission Record indicated the facility admitted the resident on

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3/6/2024 with diagnoses that included acute and chronic respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen), COVID-19, and dependence on supplemental oxygen.

A review of Resident 20's MDS dated 4/19/2024, indicated the resident usually was able to understand others and usually was able to make herself understood. The MDS further indicated the resident required partial assistance with eating, oral hygiene, and upper body dressing, and required maximum assistance with lower body dressing and putting on footwear, bathing, and toileting.

1c. A review of Resident 28 's Admission Record indicated the facility admitted the resident on 4/16/2024 with diagnoses that included fracture of the right femur (the thigh bone), hypertension, and immunodeficiency.

A review of Resident 28's MDS dated 4/18/2024, indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS further indicated the resident required partial assistance with eating, oral hygiene, and personal hygiene; and required maximum assistance with lower body dressing and putting on footwear, and toileting.

A review Resident 28's CP titled, "The resident is at risk for infection due to impaired immunity," initiated 4/16/2024, indicated to keep the environment clean and people with infection away; and staff would use universal precautions (measures designed to prevent transmission of diseases from blood or body fluids) as appropriate.

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A review Resident 28s CP titled, "Resident at Risk for potential adverse effects due to refusal of updated COVID-19 vaccine," initiated 4/18/2024, indicated the resident and resident representative were made aware the resident is at higher risks for severe symptoms due to not being vaccinated and staff would minimize the risk for infection.

A review Resident 28's CP titled, "High Risk for Influenza due to refusal of influenza vaccine," initiated 4/18/2024, indicated the resident and resident representative were made aware the resident is at higher risks for severe symptoms due to not being vaccinated and staff would minimize the risk for influenza infection.

A review Resident 28's CP titled, "High Risk for bacterial pneumonia related to refusal of vaccine and being greater than 65 years old," initiated 4/23/2024, indicated the resident and resident representative were made aware the resident is at higher risks for severe symptoms due to not being vaccinated and staff would minimize the risk for pneumonia infection.

During an observation on 6/4/2024 at 8:54 a.m., observed Resident 196 lying in bed with a reusable blood pressure cuff applied to the right arm. LVN 2 walked from Resident 196's bed over to Resident 20's bed in the shared room. LVN 2 stated to Resident 20 that she would take the resident's BP in just a moment. LVN 2 returned to Resident 196, removed the BP cuff, walked with the cuff over to Resident 20, and applied the cuff to Resident 20's arm. LVN 2 did not sanitize the BP cuff between residents. Shortly after, LVN 2 removed the cuff from Resident 20, walked back to Resident 196 and again placed the cuff on

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Resident 196. LVN 2 did not sanitize the BP cuff between residents. LVN 2 stated Resident 196's BP reading was better now and exited the residents' room.

During an interview on 6/4/2024 at 9:06 a.m. with LVN 2, LVN 2 stated prior to taking the BP of Residents' 196 and 20, she had taken the BP of Resident 28 and did not clean the BP cuff after use on the resident. LVN 2 stated she did not clean the BP cuff between use on residents' 28, 196, and 20. LVN 2 stated she was rushing and forgot to clean the BP cuff. LVN 2 stated she should have cleaned the BP cuff between residents for infection control reasons. LVN 2 stated BP cuffs are cleaned between residents to prevent passing microbes from one resident to another.

During a concurrent interview and record review on 6/5/2024 at 9:37 a.m. with the Director of Nursing (DON), reviewed the facility policy and procedure regarding cleaning and disinfecting of resident care items. The DON stated BP cuffs in the facility are used on multiple residents and are disinfected each time the cuff comes in contact with a resident. The DON stated when the LVN used the BP cuff on three residents without cleaning it, she did not follow the facility practice and it could have potentially led to infections in residents from exposure to different bacteria. The DON stated not disinfecting the BP cuff before and after each resident could affect the residents' health resulting in a prolonged stay in the facility. The DON stated the facility policy and procedure for cleaning and disinfecting resident care items was not followed.

A review of the facility provided policy and

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procedure titled, "Cleaning and Disinfection of Resident-Care Items and Equipment," last reviewed 1/15/2024, indicated resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection. Non-critical items include blood pressure cuffs. Most non-critical reusable items can be decontaminated where they are used (as opposed to being transported to a central processing location). Reusable items are cleaned and disinfected or sterilized between residents.

A review of the facility provided policy and procedure titled, "Infection Control," last reviewed 1/15/2024, indicated the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of the infection control policies and practices are to prevent infections in the facility and to maintain a safe and sanitary environment for residents.

2. A review of Resident 249's Admission Record indicated the facility admitted Resident 249 on 5/31/2024 with diagnoses including, but not limited to, gastrostomy status (creation of an artificial external opening into the stomach for nutritional support) and retention of urine.

A review of Resident 249's Physician Progress Note, dated 6/3/2024, indicated Resident 249 can make his needs known, but cannot make medical decisions, and had a gastrostomy tube (GT - a tube inserted through the wall of the abdomen directly into the stomach used to provide nutrition,

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hydration, and or medications).

A review of Resident 249's Order Summary Report indicated Resident 249 was ordered the following:
- On 6/1/2024, catheter care for indwelling catheter (tubing inserted into the bladder [body part that stores urine] through the urethra [body part that transports urine to the outside of the body] used to drain urine) every shift.
- On 6/1/2024, enteral (involving or passing through the intestine [an organ in the digestive system]) feed order every shift for GT feeding Osmolite 1.5 (a type of tube feeding formula) at 45 ml per hour for 20 hours to provide 900 ml per 13,500 calories (a unit of energy, often used to express the nutritional value of foods) per 24 hours via enteral pump from 2:00 p.m. to 10:00 a.m., or until the dose limit is met.
- On 6/1/2024, check placement of GT before beginning a feeding and before administering medications.
- On 6/1/2024, flush GT with 30 milliliters (ml - a unit of measure for volume) warm water after medication administration.

During a concurrent observation and interview with LVN 2, on 6/5/2024, at 9:41 a.m., outside Resident 249's room, EBP signage posted outside Resident 249's room indicated providers and staff must also wear gloves and a gown for high -contact resident care activities, including device care or use, such as a feeding tube. LVN 2 stated she was going to administer Resident 249 his medications. LVN 2 checked the medication cart for Resident 249 and stated the resident's medication were not in the medication cart and she would disconnect the resident from his tube feeding and check the placement of the resident's

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GT. LVN 2 performed hand hygiene with alcohol-based hand rub (ABHR), put on gloves, and entered Resident 249's room. LVN 2 did not put on a gown prior to entering Resident 249's room. LVN 2 disconnected Resident 249 from their tube feeding, checked the placement of the GT, and flushed the GT using a syringe filled with water. LVN 2 took off her gloves, performed hand hygiene with ABHR, and exited Resident 249's room. LVN 2 stated Resident 249 is on EBP due to the resident's urinary catheter and GT. LVN 2 stated she should have worn a gown with her gloves to prevent exposing both the resident and herself to contamination. LVN 2 further stated if her clothing becomes contaminated, there is a potential to spread infection to other residents.

During an interview with the Assistant Director of Nursing (ADON), on 6/5/2024, at 4:50 p.m., the ADON stated residents who have a urinary catheter or GT need to be on EBP. The ADON stated if staff are going to have contact with residents on EBP, the staff need to wear the proper PPE, which includes a gown and gloves. The ADON further stated it is important to wear the correct PPE for infection control and to prevent the spread of infection to and from different medical devices.

A review of the facility's policy and procedure (P&P) titled, "Enhanced Barrier Precautions," dated 4/5/2024, indicated facility staff shall perform hand hygiene and will don gown and gloves before performing high-contact care activities including device care or use of urinary catheters or feeding tubes. The P&P further indicated to use EBP if the resident has a wound or indwelling medical device, without secretions or excretions that are unable to be covered or

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contained and are not known to be infected or colonized with any MDRO.

3. A review of Resident 20's Admission Record indicated the facility admitted the resident on 3/6/2024, with diagnoses including acute and chronic respiratory failure (occurs when there is a sudden decrease in the ability to exchange oxygen and carbon dioxide between the lungs and bloodstream) with hypercapnia (too much carbon dioxide in the blood), obstructive sleep apnea, and pleural effusion (occurs when fluid builds up in the space between the lung and the chest wall).

A review of Resident 20's H&P, dated 4/18/2024, indicated the resident can make needs known but cannot make medical decisions. The H&P indicated the resident had a continuous positive airway pressure (CPAP, a machine that uses mild air pressure to keep breathing airways open while sleeping) at home.

A review of Resident 20's MDS, dated 3/9/2024, indicated the resident usually had the ability to make self-understood and understand others. The MDS indicated the resident was on a BIPAP while a resident in the facility.

During an observation on 6/4/2024, at 8:33 a.m., inside Resident 20's room, observed a BIPAP machine at the resident's bed side. The BIPAP machine's mask and tubing was dated 5/17/2024.

During an interview on 6/5/2024, at 10:33 a.m., with the ADON, the ADON stated the BIPAP mask and tubing should be changed every week to prevent the resident from acquiring infection.

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A review of the facility's recent policy and procedure titled, "Respiratory Treatments," last reviewed on 1/15/2024, indicated replace all tubing on a weekly basis.

A review of the facility's recent policy and procedure titled, "Policies and Practices- Infection Control," last reviewed on 1/15/2024, indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control.

4. During an observation and interview on 6/4/2024, at 9:07 a.m., at the hallway near rooms A and B, with Certified Nursing Assistant 1 (CNA 1), observed two mechanical lifts (mobility tool used to safely move residents from one surface to another with minimal physical effort) with cloth slings hanging on each machine with grayish powdery dust particles on the slings. CNA 1 stated the slings were used on multiple residents. CNA stated they use sanitary wipes to clean the slings before and after each resident use.

During an interview on 6/5/2024, at 8:25 a.m., with the Maintenance Director (MD), the MD stated staff should have not left the slings hanging on the mechanical lift. The MD stated the used slings should be bagged and sent to laundry for washing. The MD stated they only have cloth slings in the facility. The MD stated the cloth sling was for single resident use only to prevent spread

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of infection.

A review of the facility's Lift Equipment 1 (LE 1) Manual, undated indicated the sling should be regularly washed in water, temperature not to exceed 180 degrees F (82 degrees C), and a biocidal (anti-biological) solution. A soft cloth, dampened with water and a small amount of mild detergent, is all that is needed to clean the patient lift. The lift can be cleaned with non-abrasive cleaners.

A review of the facility's recent policy and procedure titled, "Policies and Practices- Infection Control," last reviewed on 1/15/2024, indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control.

5.a. A review of Resident 13's Admission Record indicated the facility admitted the resident on 8/29/2023, and was readmitted on 5/17/2024, with the diagnoses that included, but not limited to chronic obstructive pulmonary disease (COPD - long term lung disease making it hard to breathe), emphysema (a type of COPD that affects the air sac of the lungs), and dependence on supplemental oxygen (a machine that provides oxygen).

A review of Resident 13's History and Physical (H&P), dated 5/20/2024, it indicated the resident

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was readmitted to facility on 5/17/2024 from a general acute care hospital (GACH) for sepsis (a serious condition when the body overreacts to an infection) caused by pneumonia (PNA - an infection that affects one or both lungs). The H&P indicated the resident has the capacity to understand and make decisions.

A review of Resident 13's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/23/2024, it indicated Resident 13 had the ability to make self-understood and had the ability to understand others. The MDS indicated Resident 13 required moderate assistance with bed mobility, dressing, toilet use, and personal hygiene.

A review of Resident 13's Order Summary Report printed on 6/05/2024, it indicated on 5/29/2024, Resident 13's physician ordered supplemental oxygen via NC as needed (PRN), and to change the NC every week on Fridays and PRN for soilage and infection control.
During a concurrent observation and interview on 6/4/2024, at 11:30 a.m. with Licensed Vocational Nurse (LVN) 1, inside Resident 13's room, Resident 13's NC was not labeled with the date it was last changed. LVN 1 stated the NC is changed every Friday on night labeled with the date to prevent the growth of bacteria in the tubing that can cause respiratory infections.

A review of Resident 37's Admission Record indicated the facility admitted the resident on 4/17/2024, and was readmitted on 5/21/2024, with the diagnoses that included, but not limited to asthma (long term lung disease, causing swelling and tightening of the lungs and making it hard to breathe), shortness of breath (SOB - the feeling

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of tightening of the chest making it hard to breath) and cough.

A review of Resident 37's H&P, dated 5/23/2024, it indicated the resident has the capacity to understand and make decisions.
A review of Resident 37's MDS dated 5/24/2024, it indicated Resident 37 had the ability to make self-understood and had the ability to understand others. The MDS indicated Resident 3 is dependent on staff for dressing, toilet use, and personal hygiene.

A review of Resident 37's Order Summary Report printed on 6/05/2024, it indicated on 4/23/2024, Resident 37's physician ordered supplemental oxygen via NC PRN and to change the NC tubing every week on Fridays and PRN for soilage.

A review of Resident 37's Care Plan focused on asthma dated 5/24/2024, it indicated to monitor Resident 37 for any signs of an impending (likely to happen soon) asthma attack and provide supplemental oxygen PRN.
During a concurrent observation and interview on 6/4/2024, at 11:40 a.m. with LVN 1, inside Resident 37's room, Resident 37's NC was not labeled with the date it was last changed. LVN 1 stated the NC is changed every Friday on night labeled with the date to prevent the growth of bacteria in the tubing that can cause respiratory infections.

During an interview on 6/4/2024 at 11:55 a.m. with Assistant Director of Nursing (ADON), the ADON stated Resident 13 and 37's NC is changed very Friday night for infection control purposes. ADON further stated if the NC is not labeled, they cannot ensure it was changed within

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F 880	Continued From page 138 the last week. ADON also stated not changing the NC weekly could lead to a build-up of bacteria or viruses in the tubing and cause an infection. A review of the facility's policy and procedure titled, "Policies and Practices - Infection Control," revised on 1/15/2024, it indicated, "This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.	F 880		