STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555400	A. BUILDING _____ B. WING _____	C 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE CARE CENTER	500 JESSIE AVENUE SACRAMENTO, CA 95838

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. The facility census was 156. The sample size was 37. One (1) complaint #CA00918751 was investigated during the Recertification Survey. The Department substantiated complaint #CA00918751, and the findings are written under tag F685.	F 000	POC Received 10/4/24 POC Approved 10/8/24 BIC = 10/1/24 per MK	
F 550 SS=E	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 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	F 550		10/1/24

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

Electronically Signed | 10/04/2024

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 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 promote, maintain, and treat five of 37 sampled residents (Resident 77, Resident 119, Resident 44, Resident 21, and Resident 6) with respect and dignity when: 1. Resident 77 was not provided with privacy when receiving phone calls; 2. Resident 119's requests were ignored; 3. Residents were referred to as "feeders" and residents were not asked if they wanted to wear a bib during a meal; 4. Certified Nursing Assistant (CNA) 6 was standing while feeding Resident 21 and 44; and 5. Resident 6 was not provided with privacy during medication administration. These failures increased the potential for	F 550	F550 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice	

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F 550	Continued From page 2 residents not to be able to exercise their rights for privacy, to be treated with dignity and respect, and to receive the services and care necessary to maintain their highest possible mental, physical, psychological, and social well-being. Findings: 1. A review of Resident 77's Admission Record indicated he was admitted with diagnoses including seizures (sudden and uncontrolled body movements due to abnormal electrical activity in the brain) and vascular dementia (problems with memory, judgment and other thought processes from impaired blood flow to the brain). A review of the Resident 77's Minimum Data Set (MDS, an assessment tool), dated 9/25/23, indicated Resident 77 had severe cognitive impairment. Resident 77's interview for daily preferences indicated he chose the "Very important" response option when he was asked, "While you are in this facility how important is it to you to be able to use the phone in private?" During the Resident Council Meeting on 9/12/24 starting at 10 a.m., Resident 77 stated he used the telephone in the nursing station when he talked with his family and there were other people nearby. In an interview on 9/12/24 starting at 10:47 a.m., the Administrator (ADM) stated the facility had no handheld phones for residents to use. The ADM further stated the residents use the phone in the nursing station and there was no privacy of calls at the nursing station.	F 550	does not reoccur; 1. A series of in-services were conducted by the Director of Staff Development (DSD) to the CNA□s on Resident□s rights including, patient dignity, one-on-one feeding assistance, and patient cloth protector protocol. The dates of these in-services were 9/30/24 and 10/1/24. 2. The administrator conducted an in-service in an all-staff meeting on 9/20/24 with monthly reminders. In this in-service, the importance of customer service and responding to patients□ requests was covered. 3. The Director of Nursing (DON) conducted an in-service with the licensed nurses on 9/23/24 on Medication administration. This in-service included administering medications in accordance with the resident□s preferences, which include resident privacy. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 DSD, DON, and Administrator will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality	

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F 550	Continued From page 3 A review of the facility's policy and procedure revised February 2021 and titled, "Resident Rights" indicated, "... Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to... communicate in person and by mail, email and telephone with privacy..." 2. According to the admission records, the facility admitted Resident 119 in August 2024 with multiple diagnoses which included anxiety, depression and dementia. A review of the MDS dated 8/27/24 indicated Resident 119 was cognitively intact and had no memory problems. During an observation and interview on 9/11/24 at 8:15 a.m., Resident 119 was sitting on his bed, alert and pleasant. Resident 119 stated that sometimes facility staff ignored him and added, "Yesterday I needed help and I went looking for my CNA. Stopped four of them in the hall, attempted to ask for help, but all of them ignored me and kept walking in the hall. [They treated me] like I don't exist." Resident 119 added, "It is very disturbing ... if they ignore someone that can communicate [their] needs, how will they respond to someone that can not talk, but needs something." During a continued interview on 9/11/24 commencing at 8:15 a.m., Resident 119 stated that he has been having issues with other residents coming to his room. Resident 119 stated that a few days ago, a female resident entered his room in a wheelchair and grabbed a drink from his tray while he was eating. Resident	F 550	Assurance meeting. 2. Additional in-services will be conducted to ensure maintenance of compliance. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 10/1/2024.	

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F 550	Continued From page 4	F 550		

119 added, "I did not like her touching my things and food, but she did not listen and would not leave my room. It took a while for them [staff] to get her out of my room after I went and told them."

Resident 119 further stated that a few nights ago, he was attempting to fall asleep when another resident opened his curtain and stood there staring at him. Resident 119 continued, "I felt uncomfortable, felt like my privacy was violated and couldn't sleep. [I] went to the station where four nurses were sitting, explained what is going on and asked them to remove her. They were sitting and chatting at the desk. They laughed at me and one of then said, "You are such a cute little guy so maybe she wants to get into bed with you." Resident 119 stated he felt humiliated that staff treated him like a kid and continued asking to get the resident out of his room until they finally escorted the female resident out of his room.

During an interview on 9/11/24 at 3:24 p.m., Licensed Nurse (LN 1) described Resident 119 as "very nice, alert and oriented." LN 1 stated Resident 119 liked to come to the nursing station and asked different questions.

On 9/12/24 at 1:35 p.m., the Department discussed Resident 119's concerns with privacy and dignity during a joint interview with Director of Nursing (DON) and ADM. The DON stated that her expectation was that each resident was treated with dignity and respect at any time. The DON stated she was familiar with Resident 119 and talked to him frequently and added that the resident was alert and able to verbalize his needs

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F 550	Continued From page 5 and wants. During a visit to Resident 119's room accompanied by DON on 9/12/24 at 2:10 p.m., the resident was able to verbalize the DON's name and her title. During a conversation, Resident 119 shared with DON that a few days ago a female resident came to his room and took his drink. In a continued interview, Resident 119 explained about the incident when another female resident invaded his privacy and was staring at him while he was attempting to sleep. Resident 119's story was consistent word for word what he had told the Department two days prior and he recalled that four nurses at the nursing station laughed at him and one of them had told him that maybe that female resident wanted to get into bed with him. Resident 119 added, "Disturbing, I felt humiliated, treated me like a kid." A review of the facility's policy titled, "Resident Rights,"dated 2001, indicated, "Employees shall treat all residents with kindness, respect, and dignity." 3. During an observation on 9/10/24 at 12:38 p.m. of multiple residents in the Fireside dining room during lunch service, observed blue terry cloth bibs on most residents. Observed staff distributing meals from carts. Observed staff assisting three residents with eating their meals. During an interview on 9/10/24 at 12:53 p.m. with the Registered Dietitian (RD) in the Fireside dining room while residents were eating lunch, the RD stated, "Residents are supervised by staff during meals because some are feeders."	F 550		

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F 550	Continued From page 6 During an interview on 9/10/24 at 12:57 p.m. with the Unit Manager (UM) in the Fireside dining room during lunch service , the UM stated, "We try to have residents all wear bibs because it can get messy." When asked if staff were asking residents' permission to wear bibs, the UM stated that currently staff is not asking the residents' permission to wear a bib. The UM then stated, "Should be asking if want to wear bibs. They have the right to refuse." During an interview on 9/12/24 at 1:22 p.m. with the DON, the DON stated residents should not be referred to as feeders and staff should be corrected. A review of the facility's Policy and Procedure (P&P) titled "Dignity," revised 2/21, indicated "...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...When assisting with care, residents are supported in exercising their rights...provided with a dignified dining experience...Staff speak respectfully to residents at all times, including...not "labeling" or referring to the resident by his or her...care needs..." A review of the facility's P&P titled "Resident Rights," revised 2/21, indicated "...Employees shall treat all residents with kindness, respect, and dignity...Federal and state laws guarantee certain basic rights to all residents of this facility. These include the resident's right to self-determination..." 4. During an observation on 9/10/24 at 12:07	F 550		

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F 550	Continued From page 7	F 550		

p.m. in Wanderhall Dining Room, CNA 6 was feeding Resident 44 standing in front of the resident's chair. CNA 6 put a spoon full of food to the resident's mouth repeatedly with minimum wait time, CNA 6 completed feeding Resident 44 at 12:11 p.m. The lunch meal comprised of main course, dessert, milk, and water.

During an observation on 9/10/24 at 12:36 p.m. in the Wanderhall Dining Room, CNA 6 was feeding Resident 21 dessert while standing.

During an interview on 9/10/24 at 12:48 p.m. with CNA 6, CNA 6 stated the [dining] room was full, she had to stand up while feeding Resident 44. She further stated when feeding a resident, CNAs were supposed to sit down, but was not sure why they should sit down.

During an interview on 9/10/24 at 1:06 p.m. with the Director of Staff Development (DSD), the DSD stated staff should sit down while feeding a resident for dignity and respect, it should be at eye level of the resident.

During an interview on 9/13/24 at 11:55 a.m. with the DON, the DON stated CNAs should sit down or at eye level [of the resident while feeding], it was for residents' dignity.

During a review of the facility's P&P titled, "Dignity" revised 2/2021, the P&P indicated, "1. Resident are treated with dignity and respect at all times...5. When assisting with care, residents are supported in exercising their rights, For example, Residents are:...e. provide with a dignified dining experience."
5. A review of a Resident 6's Admission Record

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F 550	Continued From page 8 indicated the resident was admitted to the facility in early 2023 with admitting diagnosis of Type 2 Diabetes (a chronic condition in which the body has trouble controlling sugar in the blood). Resident 6's MDS, dated 7/1/24, indicated resident had severe cognitive impairment. During a Medication Administration observation on 9/11/24 at 8:21 a.m., LN 2 was observed to prepare and administer Resident 6's insulin aspart (medication to lower blood sugar level). During a Medication Administration observation on 9/11/24 at 8:30 a.m., Resident 6 was sitting in her wheelchair in the middle of the room, with eyes closed. Three other residents in the room were in their beds. LN 2 administered 2 units of insulin aspart to Resident 6 without offering privacy. LN 2 pulled up Resident 6's dress and exposed the resident's disposable brief and abdomen while the roommates were watching. During an interview on 9/11/24 at 2:50 p.m. with the DON, the DON stated her expectation of the LN was to pull the privacy curtain in the room to offer privacy. The DON further stated the LN should communicate with the resident and follow the 5 rights of medication administration. During a review of facility's policy and procedure titled, "Dignity," revised February 2021, indicated "11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with...treatment procedures."	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		9/23/24

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F 554	Continued From page 9 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that one of 37 sampled residents (Resident 119), who was observed with cold and allergy nasal spray at the bedside, was assessed and had an order to self-administer medication. This failure had the potential to result in overmedication for Resident 119 and exposed other residents to accidental access to the nasal spray. Findings: According to admission record, the facility admitted Resident 119 in August 2024 with multiple diagnoses which included chronic lung disease and anxiety. A review of the Minimum Data Set (MDS, an assessment and care planning tool) dated 8/27/24, indicated Resident 119 was cognitively intact and had no memory problems. A review of Resident 119's clinical record contained a document titled, "Nursing - Self-Administration of Medication Observation," dated 8/21/24 at 8:52 p.m. The document had the following question, "Does resident want to self-administer medications?" and the nurse who performed the assessment documented "No." There was no further documented evidence indicating Resident 119 was able to	F 554	F554 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents have been affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. Upon admission all patient belongings will be labeled and noted in inventory sheet by the receptionist. Any medications identified will either result in the creation of a care plan for self-administration if necessary or the responsible party will be contacted to pick the item up. 2. An in-service was conducted on 9/23 by the Director of Nursing (DON) to licensed nurses on medication administration, including self-administration of medication for residents.	

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F 554	Continued From page 10 self-administer medications. During an interview on 9/11/24 at 3:24 p.m., Licensed Nurse (LN 1) described Resident 119 as very nice, alert and oriented. LN 1 stated Resident 1 came up to the nursing station quite often to talk to nurses. During an interview and concurrent record review with Director of Nursing (DON) and Administrator (ADM) on 9/12/24 at 1:35 p.m., the DON stated she was familiar with Resident 119 and talked to him frequently. The DON stated Resident 119 was alert and able to verbalize his needs and wants. During a visit to Resident 119's room accompanied by DON on 9/12/24 at 2:10 p.m., a container of Neo-Synephrine extra strength nasal spray (a medication used to relieve nasal congestion) was observed on top of resident's nightstand. The container had resident's name printed on the bottom. Resident 119 explained that for days he kept asking nurses to ask the physician to prescribe the nasal spray, but nobody followed up his request and he was using his own medication which he brought from home. The resident stated the name of the staff who allowed him to keep the spray at bedside and printed his name on the container. The DON explained that it was not safe to keep any medication at bedside because other residents could get hold of it and attempt to consume it not realizing that it was not safe. A review of the facility's policy titled, "Self-Administration of Medications," revised 2/2021 indicated that residents had the rights to	F 554	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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. Care plans will be implemented for all residents able to self-administer medication. 2. Upon admission, residents belongings will be taken for inventory to ensure there is no medication for the patient to self-administer if applicable. 3. Medical Records will conduct daily audits to ensure all care plans are in place as necessary. This report will be given to the DON or designee daily to correct any errors. 4. This team of department heads will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. Facility is in compliance as of 9/23/2024	

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F 554	Continued From page 11 self-administer medications if the interdisciplinary team determined that it was clinically appropriate and safe for residents to do so. The policy indicated, "If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical records and care plan ...If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications...Self-administered medications are stored in a safe and secure place, which is not accessible by other residents...Any medications found at bedside that are not authorized for self-administration are turned over...for return to the family or responsible party." During a follow up interview on 9/13/24 at 10:20 a.m., the DON explained the process of self-administration of medications that she expected nurses to follow. The DON stated that nurses should assess if the resident was able to self-administer any medication safely and the resident should have a physician order for specific medication the resident was allowed to self-administer. The DON stated Resident 119 should not have medicated spray at bedside because it was not safe for him and because other residents could have access to the medication. The DON stated the expectation was that if the nurse knew about the medication, the nurse should have explained to the resident why he could not keep it at bedside and removed the spray.	F 554		
F 578 SS=E	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	F 578		9/30/24

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NORTH POINTE CARE CENTER	500 JESSIE AVENUE SACRAMENTO, CA 95838

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F 578	Continued From page 12 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 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	F 578		

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F 578	Continued From page 13 by: Based on interview and record review, the facility failed to ensure the POLST (Physician Orders for Life-Sustaining Treatment which include code status with instructions on what to do if the resident had no pulse and stopped breathing) forms were completed and updated when: 1. Two of 37 sampled residents' (Resident 3 and 44) POLST forms were not signed and completed; and 2. Two of 37 sampled residents' (Resident 104 and 111) code statuses were not updated in their EMR (Electronic Medical Record) after new POLSTs were put in place. These failures had the potential to result in the facility not acting in accordance with residents' wishes and following physician orders in the event of an emergency. Findings: 1a. During a review of Resident 3's facesheet (a document that gives a resident's information at a quick glance) dated 9/12/24, it indicated Resident 3 was originally admitted to the facility on 11/4/21 and readmitted on 7/7/24, and the resident had a guardian/responsible party assigned. During a review of Resident 3's "POLST" in the paper record, prepared date 7/7/24, the POLST indicated section D regarding Advance Directive [a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or	F 578	F578 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. Medical Records conducted a full facility audit to ensure that the POLST forms matched the EMR and that the POLSTs were completed. The station 1 audit was completed on 9/18/24, and the station 2 audit was completed on 9/19/24. 2. New admissions will be screened by Medical Records (MR), Social Services Director (SSD), and the Director of Nursing (DON) on the next business day after arrival to check the POLST and ensure it is filled out and signed. Asking hospitals to send POLST upon admission. 3. Verbal verification with by two licensed nurses with the responsible party. 4. A series of in-services were conducted by the DON on 9/12/24, 9/23/24, and 9/30/24 to the licensed	

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F 578	Continued From page 14 as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated] was left blank, without any indications whether Resident 3 had an Advance Directive. "Signature of Physician/Nurse Practitioner/Physician Assistant" was also left blank. 1b. During a review of Resident 44's facesheet dated 9/12/24, it indicated Resident 44 was originally admitted to the facility on 2/18/21 and readmitted on 4/5/22, and a benefit management company was assigned to the resident as her responsible party. During a review of Resident 44's "MDS" (Minimum Data Set, a clinical assessment tool) dated 8/19/24, the MDS indicated a Brief Interview for Mental Status [BIMS, a tool used to assess cognition (knowing, learning, and understanding things)] was not conducted due to Resident 44 was rarely/never understood. A staff assessment for mental status was performed which indicated Resident 44's "Cognitive Skills for Daily Decision Making was severely impaired." During a review of Resident 44's "POLST" in the paper record, prepared date 11/23/21, the POLST indicated Resident 44 's code status was DNR (do not attempt resuscitation), and section D regarding Advance Directive was left blank, without any indications whether Resident 44 had an Advance Directive. "Signature of Physician/Nurse Practitioner/Physician Assistant" was also left blank. During an interview on 9/13/24 at 10:20 a.m. with	F 578	nurses on the process of completing the POLST forms. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 Medical Records Director, Social Services Director, and Director of Nursing review the POLST on the first business day after arrival of the new admission to ensure the POLST is completed properly. 2. This team of department heads will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/30/2024	

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F 578	Continued From page 15	F 578		

the Medical Records Director (MRD), the MRD stated Resident 3 and 44 did not have Advance directives in their records.

During a concurrent interview and record review on 9/13/24 at 10:36 a.m. with the Director of Nursing (DON), Resident 3 and 44's POLST forms were reviewed, the DON confirmed section D of the forms were left blank. She stated nurses and medical records were responsible to complete and audit the completion of the form, she was not sure if the family provided any Advance Directive information and why the staff did not fill it out. She further stated if a POLST was not signed by a physician, it was not a valid document. Even if the form stated DNR, without a physician's signature the resident should remain full code (attempt resuscitation/CPR).

During a review of the "Direction for Health Care Provider" on completing POLST effective date 4/1/17, the direction indicated "POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistence, and update forms appropriately to resolve any conflicts. POLST must be completed by a health care provider based on patient preferences and medical indications...To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker."

During a review of the facility's policy and procedure (P&P) titled "Advance Directives," revised 9/2022, the P&P indicated, "Determining

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F 578	Continued From page 16 Existence of Advance Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 3. Written information about the right to accept or refused medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative. 4. Written information includes a description of the facility's policies to implement advance directives and applicable state law." 2a. A review of Resident 104's clinical record indicated Resident 104 was admitted in September 2022 with diagnoses including dementia (loss of cognitive functioning that affects daily life and activities). A review of Resident 104's physician's order dated 7/19/24 indicated, "May admit to [name of hospice] with a terminal dx. [diagnosis]...". Resident 104 had no physician order for her code status. Further review of Resident 104's clinical records indicated she had two (2) POLSTs. The POLST dated 5/24/22 indicated, "Attempt Resuscitation...Full Treatment...". The new POLST dated 7/18/24 indicated, "Do Not Attempt Resuscitation/DNR...Comfort-Focused Treatment..."	F 578		

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F 578	Continued From page 17	F 578		

In a concurrent interview and record review on 9/11/24 at 10:36 a.m., the Unit Manager (UM) confirmed Resident 104 had two (2) POLSTs in the paper chart. The UM further confirmed Resident 104's electronic record indicated "(Advance Directive)" in her code status and the UM was unable to locate the advance directive. The UM stated the new POLST, dated 7/18/24, was not uploaded in the electronic record.

In a concurrent interview and record review on 9/13/24 at 10:25 a.m., the MRD stated Resident 104 had no advance directive as indicated in her POLST.

2b. A review of Resident 111's clinical record indicated Resident 111 was admitted in July 2023 with diagnoses including dementia.

A review of Resident 111's physician's order dated 3/20/24 indicated, "Full Code [all life-saving measures will be performed by the medical team if the heart or lungs stop working]". The POLST dated 9/6/24 and signed by the physician on 9/8/24 indicated, "Do Not Attempt Resuscitation/DNR..."

In an interview on 9/11/24 at 9:42 a.m., the UM confirmed the above finding and stated Resident 111's code status was not updated in the electronic record. The UM stated her assumption was when the physician signed the new POLST, this was put back in the chart instead of notifying medical records of the change.

In an interview on 9/11/24 at 4:18 p.m., the DON stated her expectation was for the code status to be updated when the POLST was changed.

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F 578	Continued From page 18 In an interview on 9/12/24 at 8:25 a.m., the DON stated they do not have a policy and procedure for the POLST. The DON further stated the facility follows the "Directions for Health Care Provider" written at the back of the POLST form. A review of the "Directions for Health Care Provider" indicated, "...When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts." In an interview on 9/13/24 at 10:43 a.m., the DON stated the danger of the POLST not being updated in the clinical record was the facility to not be able to follow the resident's wish or directive. The DON further stated the code status should be consistent in the clinical records to avoid confusion for licensed staff.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken),	F 583		9/20/24

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F 583	Continued From page 19 written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the resident's right to privacy and confidentiality of personal and medical records for a census of 156 residents when computer screen that showed confidential personal and medical information was left unsecured. This failure had the potential to result in unauthorized access of residents' personal and medical information. Findings: During a concurrent observation and interview on 9/10/24 at 10:58 a.m. in the hallway with the Wound Nurse (WN), a computer in medication cart B was observed open with resident clinical	F 583	F583 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur;	

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F 583	Continued From page 20 information including resident's picture, name, and medications displayed. Multiple residents and staff were also observed walking in the hallway. The WN came out of a resident's room and confirmed the observation and stated, "It's a HIPAA (Health Insurance Portability and Accountability Act - a federal law that protects sensitive health information from being disclosed without consent) violation, this is resident medical information." During an interview on 9/10/24 at 10:59 a.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed he was using the computer and had to attend to a resident and stated, "I should have not kept it open because it contains important information." During an interview on 9/12/24 at 3:36 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, "The expectation for computers is staff should lock the screen if they are not using it ...It's HIPAA, everybody who is walking [in the hallway] can see the information." During an interview on 9/12/24 at 3:47 p.m. with the Director of Nursing (DON), the DON stated, "We don't leave our computers open, if not doing anything, just close it...Anybody can see somebody else's information and it's a violation of HIPAA." During a review of the facility's policy and procedure (P&P) titled "Dignity," revised 2/2021, the P&P indicated, "10. Staff protect confidential clinical information." During a review of the facility's P&P titled "Resident Rights," revised 2/2021, the P&P	F 583	1. An in-service was conducted by the Director of Nursing (DON) on 9/20/24 for the licensed nurses on HIPAA and personal confidentiality of patient records. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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. Any further HIPAA concerns will be brought to the attention of the Administrator or DON. 2. This team of department heads will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/20/2024	

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F 583	Continued From page 21 indicated, "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ...t. privacy and confidentiality...3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues." During a review of the facility's P&P titled "Confidentiality of Information and Personal Privacy," revised 2/2021, the P&P indicated, "Our facility will protect and safeguard resident confidentiality and personal privacy...1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records."	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		10/4/24

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F 584	Continued From page 22 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a homelike environment was provided for three of 37 sampled residents (Residents 18, 41, and 74), when there were no clocks available in the residents' rooms. This failure increased the potential for the residents not attaining their highest practicable well-being. Findings: During a review of Resident 18's admission	F 584	F584 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice.	

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F 584	Continued From page 23 records, the records indicated Resident 18 was admitted to the facility in December 2022 with diagnoses which included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), mood disorder, and dementia (impaired memory). During a review of Resident 18's Minimum Data Set (MDS, an assessment tool), dated 6/24/24, the MDS indicated Resident 18 had severe memory impairment. The MDS further indicated that it is very important for Resident 18 to do her favorite activities and choose her own bedtime. During a review of Resident 18's care plan initiated on 1/12/23, the care plan indicated, "[Resident 18] needs to engage in activities of choice to maintain her social needs...Assure awareness of activity schedule. Schedule time to pursue activity of choice...Identify time, location and the benefits of participating in activities." During a review of Resident 41's admission records, the records indicated Resident 41 was admitted to the facility in September 2018 with diagnoses which included Alzheimer's disease, depression, Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder, and dementia. During a review of Resident 41's MDS, dated 8/26/24, the MDS indicated Resident 41 had severe memory impairment and that it is very important for Resident 18 to do her favorite activities and choose her own bedtime. During a review of Resident 41's care plan initiated on 1/13/23, the care plan indicated,	F 584	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. Clocks have been installed in each of the residents□ rooms. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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. A monthly inventory check will be conducted by the Maintenace Director to ensure that each room has a clock. He will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 10/4/2024.	

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"[Resident 41] prefers to do independent activities (i.e. [in other words] reading)...She is at risk for social isolation...Assure awareness of activity schedule. Schedule time to pursue activity of choice...Identify time, location and the benefits of participating in activities."

During a review of Resident 74's admission records, the records indicated Resident 74 was admitted to the facility in October 2019 with diagnoses which included schizoaffective disorder (a mental health condition with symptoms of both schizophrenia and mood disorders), depression, anxiety disorder, and dementia.

During a review of Resident 74's MDS, dated 10/23/24, the MDS indicated Resident 74 had severe memory impairment and that it is very important for Resident 74 to choose her own bedtime.

During a review of Resident 74's care plan initiated on 1/13/23, the care plan indicated, "Needs extra encouragement to attend activities of choice...Assure awareness of activity schedule. Schedule time to pursue activity of choice...Identify time, location and the benefits of participating in activities."

During a concurrent observation and interview on 9/10/24 at 9:50 a.m. with Resident 41 in her room, there was no clock observed inside the room and Resident 41 stated, "There's no clock here, we need a clock in this room."

During a concurrent observation and interview on 9/10/24 at 10:20 a.m. with Resident 74 in her

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room, there was no clock observed inside the room and Resident 74 stated, "I don't know what time it is, it's important for me to know the time."

During a concurrent observation and interview on 9/10/24 at 4 p.m. with Resident 18 in her room, there was no clock observed inside the room. When asked how she knows the time, Resident 18 stated, "That's another thing that I'm upset about. They don't let me have anything."

During a concurrent observation and interview on 9/12/24 starting at 10:42 a.m. with Unit Manager (UM) in Residents 18, 41, and 74's rooms, the UM verified there were no clocks inside the three rooms. The UM stated, "I think orientation to time is important for the residents, I would like them to have that [clock]."

During an interview on 9/12/24 at 3:36 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, "There are no clocks in the room, I don't know why."

During an interview on 9/12/24 at 3:47 p.m. with the Director of Nursing (DON), when asked if there are situations when clocks are not allowed in a room, the DON stated, "I don't think so, no contraindications for wall clocks...nobody ever came up to me...If someone have told me, I would definitely address that."

During a review of the facility's policy and procedure (P&P) titled "Dignity," revised 2/2021, the P&P indicated, "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

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F 584	Continued From page 26 self-esteem." During a review of the facility's P&P titled "Homelike Environment," revised 2/2021, the P&P indicated, "Residents are provided with a safe, clean, comfortable and homelike environment...1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences."	F 584		
F 658 SS=D	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 interview and records review, the facility failed to ensure one of 37 sampled residents (Resident 119) received treatment and care in accordance with professional standards and practice, when the facility did not follow up on resident's request for allergy medication for six days. This failure resulted in a delay of Resident 119's allergy medication. Findings: According to admission records, the facility admitted Resident 119 in August 2024 with multiple diagnoses which included chronic lung disease and anxiety.	F 658	F658 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No patients were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All patients have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur;	9/23/24

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F 658	Continued From page 27 A review of the Minimum Data Set (MDS, an assessment and care planning tool) dated 8/27/24 indicated Resident 119 was cognitively intact and had no memory issues. During an observation and interview on 9/11/24 at 8:15 a.m., Resident 119 was sitting on his bed, alert and pleasant. Resident 119 stated that sometimes facility staff ignored him and added, "I have a severe allergy. Have been asking [nurses] for medication for days and they keep saying that doctor has not prescribed yet." A review of Resident 119's clinical record contained nursing progress note dated 9/6/24 at 8:55 a.m., indicating, "Resident requested for an allergy spray Fluticasone [an allergy nasal spray]. MD [Medical Doctor] notified ...Awaiting for response back." A review of Resident 119's clinical record on 9/12/24 indicated there was no documented evidence the facility followed up on resident's request. Further review of the clinical record contained no active order for Fluticasone or any other allergy medication. Resident 119's medication administration records (MARs) did not reflect that the resident was receiving Fluticasone. During an interview on 9/11/24 at 3:24 p.m., Licensed Nurse (LN 1) described Resident 119 as very nice, alert and oriented. LN 1 stated Resident 1 came up to nursing station quite often to talk to nurses. LN 1 stated he could not remember if Resident 119 asked for anti-allergy medication. LN 1 stated that if resident requested medication, the nurses communicated with the	F 658	1. An in-service was conducted on 9/23/24 by the Director of Nursing (DON) to the licensed nurses. The topic was on medication administration with one main emphasis being that medication is administered within compliance with prescribers orders. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 Medical Records Director will conduct daily audits on following up with the Physician. Any error on this task will be reported to the DON the following day. 2. This team of department heads will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/23/24	

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resident's physician regarding resident's request and obtained the order.

During an interview and concurrent record review with Director of Nursing (DON) and Administrator (ADM) on 9/12/24 at 1:35 p.m., the DON stated she was familiar with Resident 119 and talked to him frequently. The DON stated Resident 119 was alert and able to verbalize his needs and wants. The DON was asked if there was any follow up on resident's request for Fluticasone dated 6 days ago. The DON searched Resident 38's nursing progress notes and was unable to find any follow up documentation regarding the resident's request for Fluticasone. The DON stated she did not see the order for Fluticasone in Resident 38's clinical record. During a further search of the internal communication system (between physician and staff), the DON located a physician's note related to resident's request. The DON stated the note from physician was undated and it contained an order that it was okay for Resident 38 to receive Fluticasone 1 spray each nostrils for two weeks. The DON stated that the order for Fluticasone was not transcribed into Resident 119's clinical record. The DON stated her expectation for nurses was that they followed up on their communication with physician, reviewed communication notes the same day, transcribed it into Resident 38's active orders, and carried out the order in a timely manner.

A review of the 'Nursing Practice Act,' issued by the Board of Registered Nursing, indicated, "Article 2. Scope of Regulations 2725(b). The practice of nursing...means those functions, including basic health care, that help people cope

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F 658	Continued From page 29 with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skills, including...Observation of signs and symptoms of illness...general behavior, or general condition...implementation, based on observed abnormalities, of appropriate reporting, or referral...or changes in treatment regimen in accordance with standardized procedures..."	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 37 sampled residents (Resident 138) received necessary services to ensure proper grooming when Resident 138 had black material under her nails. This failure had the potential to cause infection to Resident 138 due to poor hygiene. Findings: A review of Resident 138's "Admission Record" indicated Resident 138 was admitted to the facility in October 2023 with multiple diagnoses including dementia (loss of memory, problem solving, and thinking abilities).	F 677	F677 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur;	9/20/24

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F 677	Continued From page 30 A review of Resident 138's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 8/5/24, indicated Resident 138 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 5 out of 15 that indicated Resident 138 had severe cognitive impairment. A review of Resident 138's MDS, Functional Abilities and Goals, dated 8/5/24, indicated Resident 138 required moderate assistance for personal hygiene. During an observation on 9/11/24 at 9:37 a.m. of Resident 138, observed black material under Resident 138's fingernails. During a concurrent observation and interview on 9/12/24 at 9:15 a.m. with Licensed Nurse (LN) 3, observed Resident 138's fingernails with black material under nails. LN 3 confirmed that Resident 138's fingernails had black material under nails. LN 3 stated Resident 138 has a behavior of ripping off her brief and the black material under her nails may have been from soiled brief. LN 3 stated that when residents are showered the nails are supposed to be cleaned. During a concurrent observaton and interview with Certified Nursing Assistant (CNA) 7, CNA 7 observed Resident 138's fingernails with black material under nails. CNA 7 confirmed fingernails had black material under nails. CNA 7 stated that fingernails were dirty after breakfast today. Reviewed with CNA 7 that Resident 138's fingernails were observed with black material under nails yesterday on 9/11/24. CNA 7 stated Resident 138 receives shower two times a week and nails should be cleaned with soap and rubbed with towel to clean them. CNA 7 stated	F 677	1. In-services were conducted by both the Director of Nursing and (DON) and the Director of Staff Development (DSD) on 9/19/24 and 9/20/24 on nail care for the residents. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 DON and DSD will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting and reported on for the next 3 months. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/20/2024.	

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F 677	Continued From page 31 that on Sundays nails are clipped, cleaned, and filed. During an interview on 9/12/24 at 1:11 p.m. with the Director of Nursing (DON), the DON stated that nails should be cleaned during showers and as needed. The DON stated nails are cleaned and clipped weekly on Sundays and as needed. A review of the facility's Policy and Procedure (P&P) titled "Activities of Daily Living (ADL), Supporting," revised 3/18, indicated "...Residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming and personal and oral hygiene...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently...in accordance with the plan of care, including appropriate support and assistance with hygiene (...grooming...)..."	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 679	F679	9/30/24

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F 679	Continued From page 32 review, the facility failed to provide an ongoing activity program to meet the needs and interests for one of 37 sampled residents (Resident 44) when the activities care plan was not followed. This deficient practice had the potential to affect the resident's psychosocial well-being, self-worth and meaning in life. Findings: During a review of Resident 44's comprehensive "MDS" (Minimum Data Set, a clinical assessment tool) dated 2/19/24, the MDS indicated a Brief Interview for Mental Status [BIMS, a tool used to assess cognition (knowing, learning, and understanding things)] was not conducted due to Resident 44 was rarely/never understood. A staff assessment for mental status was performed which indicated Resident 44's "Cognitive Skills for Daily Decision Making was severely impaired." It also indicated "Preferences for Customary Routine and Activities: listen to music you like, do your favorite activities, and go outside to get fresh air when the weather is good" were "very important" to Resident 44 per family or significant other. During a review of Resident 44's activity care plan revised 7/18/23, the care plan indicated interventions including, "Participate in group activities of choice such as: sensory stimulation activities, movies entertainment 3x/week. Participate in room activities: socializing, looking at pictures and magazines. 3x/week Participate/engage in independent activities of choice such as: watching T.V. listening to music."	F 679	How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. An in-service was conducted on 9/30/24 by the Activities Director to the Activities staff. The main topic of this was complying with the patient specific activity program outlined in the patient□s care plan. This was evidenced by number 3 on the in-service agenda sheet. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 Activities Director will be conducting monthly audits to ensure that the staff are in compliance with completion of patient specific activities.	

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F 679	Continued From page 33 During an observation on 9/10/24 at 10:02 a.m. in station 2 hallway, Resident 44 was awake in the recliner and looking up the ceiling. The resident was not able to communicate. During an interview on 9/10/24 on 10:15 a.m. with Licensed Nurse (LN) 5, LN 5 stated usually Resident 44 gets up in the recliner for breakfast, she has been repositioned in the chair, not sure what activity was provided to the resident, also not sure whether resident goes to group activities. On 9/10/24 at 12:20 p.m., Resident 44 was placed in the hallway outside of her room after lunch, no interaction with staff or sensory stimulation observed. During an observation on 9/12/24 at 11:21 a.m., Resident 44 was sleeping in bed, there was no television or radio available in the room. On 9/12/24 at 1:13 p.m., Resident 44 was lying in bed awake, no sensory stimulation observed. During a review of Resident 44's facesheet (a document that gives a resident's information at a quick glance) dated 9/12/24, it indicated Resident 44 was originally admitted to the facility on 2/2021 and readmitted on 4/2022, with diagnoses of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interfered with a person's daily life and activities), and cognitive communication deficit. On 9/12/24 at 3:38 p.m., Resident 44 was still lying in bed awake without any stimulations.	F 679	2. This Activities Director will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/30/2024.	

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F 679	Continued From page 34 During an interview on 9/13/24 at 8:40 a.m. with the Activity Director (AD), the AD stated the facility has boomboxes, those go around the facility, but sometimes it breaks or goes missing. During a subsequent interview on 9/13/24 at 10:14 a.m. with the AD, she stated she was not able to provide any activity documentations for September 2024 for Resident 44, one of activity assistants was not able to get the login for POC (Point of Care, an application for direct care staff to document activities of daily living of residents) for the past four or five months. The AD further stated staff do not use other documentation methods, POC is the only way of documentation for activity staff, and admitted if it was not documented, then it was not done. During an interview on 9/13/24 at 12:02 p.m. with the Director of Nursing (DON), the DON stated activities should be documented if they were done. During a review of the facility's policy and procedure (P&P) provided by the AD, untitled and undated, the P&P indicated, "All room visits must be done 3x a week. Or make sure that the resident is attending group activities 3x a week. All room visits must be charted for that week." During a review of the facility's P&P titled, "Activities Policy and Procedure" revised 2/2023, the P&P indicated, "7. Each resident's activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs."	F 679		

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F 679	Continued From page 35 During a review of the facility's P&P titled, "Activity - Attendance Participation Record" date 12/31/15, the P&P indicated, "It is the policy for this facility that the Activity Department will keep accurate records of each resident's participation in group, individual and independent recreational/leisure time involvement...All resident activity involvement should be recorded."	F 679		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care to maintain vision for one of 37 sampled residents (Resident 143), when Resident 143 was not sent to the hospital for an acute onset vision loss. This failure had the potential to cause deterioration of vision leading to increased fall risk and greater loss of independence. Findings:	F 685	F685 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No patients were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice.	9/17/24

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F 685	Continued From page 36 A review of Resident 143's "Admission Record" indicated Resident 143 was admitted to the facility in January 2024 with multiple diagnoses including dementia (loss of memory, problem solving, and thinking abilities), malignant neoplasm of endometrium (cancer in the lining of the uterus), and diabetes (too much sugar in the blood). A review of Resident 143's Minimum Data Set (MDS- an assessment tool), Cognitive Patterns, dated 7/29/24, indicated Resident 143 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 2 out of 15 that indicated Resident 143 was severely cognitively impaired. A review of Resident 143's "SBAR [Situation, Background, Assessment, Recommendation] Communication Form [document used to communicate change in condition]" dated 7/27/24 at 4 p.m., indicated "...Vision problem...Increased confusion or disorientation...Needs more assistance with ADLs [Activities of Daily Living]...The res [resident] has more confusion than usual today. While she was walking in the hallway, she could not see what was in front of her and she could hit on it. The nurse assessed her vision by let her count the fingers, but she was unable to focus and she was watching somewhere else and talking something those [sic] does not make sense..." A review of Resident 143's "Progress Note," dated 7/27/24 at 5:40 p.m., indicated "...The res [resident] has more confusion than usual today. While she was walking in the hallway, she could	F 685	All patients have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Director of Nursing (DON) conducted an in-service for the licensed nurses are 9/17/2024 on Change of Conditions event protocols. This in-service covered sending patients to the hospital following an acute onset event. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 Medical Records Director (MR) will complete a daily audit of Change of Conditions to ensure that the event protocol was followed. Any errors will be reported to the DON the next day for correction. 2. The DON and MR will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action	

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F 685	Continued From page 37 not see what was in front of her and she could hit on it. The nurse assessed her vision by let her count the fingers, but was unable to focus and she was unable to follow the direction...[Name of physician] notified..." A review of Resident 143's "Progress Note," dated 7/27/24 at 8:15 p.m., indicated "...[Name of physician] called with new orders...If the condition is getting worse send the PT [patient] to [name of hospital]..." A review of Resident 143's "Progress Note," dated 7/30/24, indicated "...On monitoring for visual problem...still has difficulty of vision but can identify objects in front and side by side in short distance..." A review of Resident 143's "Progress Note," dated 8/2/24, indicated "...Per [Name of Nurse Practitioner]...Refer resident to optometrist for vision consult..." A review of Resident 143's "Progress Note," dated 8/13/24, indicated "...the ophthalmologist diagnosed pt having retinal detachment with giant tear, bilateral, the res is referred to retina specialist, the decision for surgery is left to retina specialist and RP [Responsible Party]..." A review of Resident 143's "Progress Note," dated 8/19/24, indicated "...pt [patient] is back from surgery consultant appointment...pt has total retinal detachment with macular hole in both eyes..." A review of the facility's "Doctor Summary Sheet," for facility optometry group, dated	F 685	completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/17/24	

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F 685	Continued From page 38	F 685		

2/12/24, did not indicate any recommendations or ophthalmology referral needed for Resident 143.

A review of Resident 143's "Optometry Department Referral for Services/ Recommendations," dated 8/8/24, indicated "...Staff members report significant change in visual function since last exam 6 months ago only remarkable finding was cataract ou [cloudy lens in both eyes]...Referral to in-house ophthalmologist..."

A review of Resident 143's ophthalmology "Examination," dated 8/13/24, indicated "...Retinal detachment with giant retinal tear, bilateral OU...Assessment: Complete detachment ou, pt has difficulty reporting time of onset..."

During a telephone interview on 9/9/24 at 12:20 p.m. with Resident 143's Responsible Party (RP), the RP stated around the end of July 2024, Resident 143 was not able to see. The RP stated she asked the facility to send Resident 143 to the hospital, but they did not send her. The RP stated Resident 143 had an optometry appointment on 8/8/24 and ophthalmology appointment on 8/13/24. The RP stated Resident 143 had bilateral detached retinas and macular holes.

During a telephone interview on 9/9/24 at 12:36 p.m. with Resident 143's Family Member (FM), the FM stated the head nurse told him, on 7/27/24, she was not sure if Resident 143 could see. The FM stated the nurse stated, "Not sure what happened. Called doctor. Pretty sure she didn't have a stroke. Ordered some tests." The

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FM stated he observed Resident 143 shuffling her feet. The FM stated the week prior she was walking as usual and could see.

During an interview on 9/11/24 at 3:33 p.m. with Resident 143, asked if she had any eye problems. Resident 143 stated it is worse when she is moving around.

During an interview on 9/11/24 at 3:38 p.m. with Licensed Nurse (LN) 1, LN 1 stated on 7/27/24 Resident 143's vision worsened. LN 1 stated neuro (neurological) checks were done due to vision loss. LN 1 stated Resident 143 had check up with ophthalmologist, but not sure what assessment showed.

During an interview on 9/11/24 at 4:12 p.m. with LN 6, LN 6 stated Resident 143's family reported vision loss. LN 6 stated Resident 143 had a Change in Condition on 7/27/24 and the physician ordered labs. LN 6 stated that Resident 143 has retinal detachments due to diabetes and medical history.

During a joint interview on 9/12/24 at 1:11 p.m. with the Administrator (ADM) and the Director of Nursing (DON), the ADM stated that family reported Resident 143's vision was worse. The DON stated that she did not know if vision loss was sudden or not and did not think she was having a stroke. The DON stated Resident 143 has diabetes and may have had chronic eye problems related to diabetes. The physician was notified and optometry appointment was scheduled. The ADM stated Resident 143 was not sent to the hospital because the vision loss was chronic.

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F 685	Continued From page 40 During a telephone interview on 9/12/24 at 1:30 p.m. with the Medical Doctor (DR), the DR stated Resident 143 had change in her vision, but due to her dementia was not sure what that complaint meant. The DR stated that Resident 143's diabetes was well controlled and did not have significant retinopathy (abnormal blood vessels in the retina of the eye that can cause vision problems). The DR stated Resident 143 had blurry vision and her confusion was up and down so there was concern for stroke or retinal issues. The DR stated labs were ordered and Resident 143 was monitored. The DR stated if there is concern for TIA (transient ischemic attack-brief blockage of blood flow to the brain) or acute vision loss, should send out right away. The DR stated in Resident 143's case not able to determine, due to dementia, if it was acute vision loss or blurry vision, but if acute vision loss, that is an emergency and should be sent to hospital for retinal tear detachment. The DR stated Resident 143's RP was contacted and asked if she wanted to watch and wait or send her out and was okay with monitoring that day. During a telephone interview on 9/12/24 at 1:51 p.m. with LN 7, LN 7 stated on 7/27/24 Resident 143 seemed like she could not see and was more confused. LN 7 stated that Resident 143 could not see her fingers when held up. LN 7 stated Resident 143's family member was present and stated that Resident 143 could not see. LN 7 stated she wanted to send Resident 143 to the hospital. LN 7 stated she called the DR and the DR called back with lab orders. LN 7 stated she could not send out without MD order. LN 7 stated she asked the RP if she wanted to	F 685		

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F 685	Continued From page 41 send Resident 143 to the hospital. LN 7 stated she told RP, "If you want to send her out, will send her right away." LN 7 stated the RP said it was up to the doctor. During a telephone interview on 9/12/24 at 2:50 p.m. with Nurse Practioner (NP), the NP stated he was notified of Resident 1's vision loss by phone and saw Resident 143 later that day. The NP stated he did not know if the vision loss was acute, but did not think she needed to be sent to the acute care hospital. The NP stated Resident 143 was referred to ophthalmology but it took a long time to get an appointment. A review of the facility's Policy and Procedure (P&P) titled "Change in a Resident's Condition or Status," revised 2/21, indicated "...The nurse will notify the resident's attending physician or physician on call when there has been a (an): ...significant change in the resident's physical/emotional/mental condition...need to transfer the resident to a hospital treatment center...A "significant change" of condition is a major decline or improvement in the resident's status that:...will not normally resolve itself without intervention by staff...ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument..."	F 685		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		9/13/24

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F 688	Continued From page 42 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 37 sampled residents (Resident 38) received care and services in accordance with the physician order, when the staff failed to place the hand roll to the resident's right hand. This failure had the potential for Resident 38 to experience a further decline in use of her right hand and loss of ability to feed self independently, and result in skin breakdown. Findings: A review of Resident 38 Admission Record indicated the facility admitted the resident in 2016 with multiple diagnoses including muscle weakness. A review of Resident 38's Order Summary Report, dated 11/14/23, contained an active physician order for staff to apply a hand roll or	F 688	F688 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Director of Nursing (DON) conducted an in-service on 9/13/2024 on the adherence to orders for adaptive equipment.	

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F 688	Continued From page 43 soft cloth in her right hand every shift to prevent further contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joint to shorten and become very stiff). A review of Resident 38's clinical record had no care plan addressing right hand contracture and the use of hand roll daily to prevent decline in her right hand function. A review of Resident 38's care plan dated 11/12/23 indicated, Resident 38 was at risk for skin breakdown related to right hand closure. One of the interventions directed staff to check resident's skin during daily care provisions. A review of Residents 38's Minimum Data Set (MDS, an assessment and care screening tool) dated 7/31/24, indicated the resident had severely impaired cognition, impaired vision, and moderate difficulties with hearing. According to the MDS, Resident 38 had no behaviors of rejection of care. During the observations on 9/10/24 at 11:11 a.m., Resident 38 was sleeping in her bed with her right hand held close to her body. Resident's right hand was contracted with fingers curled tightly inside. There was no hand roll in her right hand. On 9/10/24 at 2:35 p.m., Resident 38 was observed dozing in her wheelchair. There was no hand roll placed in her right hand. During follow up observations on 9/11/24 at 8:22 a.m., 10:55 a.m., and 3:40 p.m., Resident 38 was observed sitting in wheelchair in her room. There was no hand roll placed in her right hand.	F 688	How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 clinical IDT team will discuss patients with adaptive devices are new orders are implemented to ensure that the order is clear and the device usage is carried out. 2. A Q15 or Q Shift check can be put in place for patients with adaptive devices if they show evidence of noncompliance with device usage. 3. The IDT, Medical Records Manager, and DON will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/13/2024.	

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F 688	Continued From page 44 During an observation on 9/12/24 at 8:53 a.m., Resident 38 was up in her wheelchair, her eyes were closed. Resident 38's hand was tightly closed, and her long nails were digging into her skin. Resident 38 did not have the hand roll in her right hand. During a concurrent observation and interview on 9/12/24 at 8:59 a.m., Certified Nursing Assistant (CNA 3) stated he was familiar with the resident's care. CNA 3 validated that Resident 38's right hand was contracted, her nails were digging into her skin, and there was no hand roll. CNA 3 stated, "This [contracture] is something new. I've never seen her hand to be closed and fingers so tight." CNA 3 stated he was not aware the resident needed a hand roll in her contracted hand. During an observation and interview with CNA 4 on 9/12/24 at 9:05 a.m., CNA 4 stated she was aware the resident's right hand was contracted. CNA 4 stated she was not aware Resident 38 needed a hand roll in her right hand. CNA 4 stated Resident 38 used to wear a brace to her right hand to prevent further contractions but was not sure what happened to the brace. During an interview with LN 2 on 9/12/24 at 9:10 a.m., LN 2 stated she was familiar with Resident 38 and her care. LN 2 acknowledged the resident had right hand contracture and stated she was not aware the resident required to have a hand roll. A review of Resident 38's medication administration records (MAR's) from 7/1/24	F 688		

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F 688	Continued From page 45	F 688		

through 9/12/24, indicated that nurses initialed every shift that the resident had a hand roll or soft cloth in her contracted right hand. There was no documentation Resident 38 refused to have a hand roll, except for morning shift on 7/15/24.

During an observation and interview on 9/13/24 at 12:40 p.m., CNA 5 was assisting Resident 38 with her lunch. Resident 38 was observed without right hand roll. CNA 5 stated, "I try to put a towel into resident's hand, but she tries to take it out."

During an observation on 9/13/24 at 12:50 p.m., accompanied by Director of Nursing (DON), observed Resident 38 sitting in wheelchair in her room. The DON validated that the resident's right hand was contracted with long nails digging into the resident's skin. The DON agreed that resident not having hand roll could eventually result in loss of ability to feed self and experience pain because nails could dig into resident's skin. The DON stated it was her expectation that the physician was notified if the resident refused to have a hand roll and a care plan should be updated to include resident's refusals. The DON acknowledged that nurses were charting that the resident had a hand roll in the right hand every shift, except one shift in July 2024. The DON stated, "Nurses should not document that the resident has a hand roll if the resident does not have it. [Should] document that [the resident] refused it." The DON confirmed that Resident 38's clinical record did not contain a care plan addressing hand contracture and hand roll. The DON validated that resident's 'At risk for skin breakdown related to right hand closure' care plan did not have interventions for resident's right

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F 688	Continued From page 46 hand contracture and did address resident's refusals for hand roll. The DON was asked for a policy on prevention of contractures and she stated there was none.	F 688		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §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	F 755		9/27/24

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F 755	Continued From page 47 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 adequately maintain pharmacy services for two out of a census of 156 when: 1. A controlled drug (medication that may be abused or cause addiction) destruction record log was inaccurate. 2. Two tablets of lacosamide (a medication given for seizures) were in one single dose unit of the medication card and not accounted for by the nursing staff. This failure had the potential to cause inaccurate accountability of controlled medications and the potential to result in diversion of the residents' medication. Findings: 1. During a review of the controlled drug destruction record log for three random resident's controlled drugs, 20 syringes of Lorazepam gel (a medication used for anxiety) was not recorded in the destruction record log. During a concurrent observation and interview on 9/11/24 at 2:55 p.m. with the Director of Nursing (DON), of the controlled medication storage in the DON's office, the DON verified that the 20 syringes of lorazepam were not documented and signed in the destruction log. The DON stated that the medication was given to her by the nurse and forgot to record it on the destruction log. The	F 755	F755 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Assistant Director of Nursing (ADON) conducted an in-service on 9/27/24 on controlled drug destruction to the licensed nurses. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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. This log is to be checked by each cart nurse at the beginning of their shift. Any errors in the medication supply or	

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F 755	Continued From page 48 DON further stated that controlled drugs should be logged with two nurses signatures. The DON confirmed that the lorazepam syringes were not recorded. The DON acknowledged that inaccurate accountability of controlled drug record logs could result in controlled drugs being diverted. 2. During an inspection of medication cart A with Licensed Nurse (LN) 3 on 9/10/24 at 9:20 a.m., the Lacomiside medication card contained two doses of the medication in one single dose unit. During a concurrent interview and record review on 9/10/24 at 9:30 a.m. with LN 3, LN 3 confirmed that there were two doses inside the medication card. LN 3 stated that the extra dose was not accounted for in the narcotic sheet record. There was no documented evidence to account for the second dose. During an interview on 9/10/24 at 9:35 a.m. with LN 3, the LN 3 stated that having two pills in one unit could have a potential risk of nursing staff administering a double dose to the resident. During an interview on 9/11/24 at 3:00 p.m. with DON, the DON stated her expectation is that if there were issues with the controlled drug medication card, the LN should have called the pharmacy to have it replaced. The DON further acknowledged that because the medication card was not replaced there was a risk that the nursing staff could potentially double dose the resident. During a review of the facility's policy and procedure titled, "Controlled Medication Storage"	F 755	destruction log will be reported to the DON immediately. 2. The ADON and DON will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/27/24	

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F 755	Continued From page 49 dated March 2018, indicated, "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to...storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations." The facility policy further indicated that "H. Controlled medications remaining in the facility after the order has been discontinued...I. The...designee routinely monitors controlled mediation storage, records..."	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (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	F 758		9/27/24

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F 758	Continued From page 50 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of 37 sampled residents (Resident 38 and Resident 150) were free of unnecessary psychotropic medications (drugs that affects behavior, mood, thoughts or perception) when: 1. Resident 38 was prescribed antipsychotic medication without specific manifested behaviors of danger to self or others; and 2. Resident 150 was prescribed a psychotropic medication without adequate indication and target behavior.	F 758	F758 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No patients were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All patients have the potential to be affected by the deficient practice.	

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F 758	Continued From page 51 These failures resulted in the use of an unnecessary psychotropic medications that could cause deterioration of health and adverse consequences. 1. A review of Admission Record indicated Resident 38 was a 98-year old admitted to the facility in 2016 with multiple diagnoses that included depressive disorder (illness characterized by sadness, feeling down or loss of interest in activities), psychosis (loss of contact with reality), and dementia. A review of Residents 38's Minimum Data Set (MDS, an assessment and care screening tool) dated 7/31/24, indicated that the resident had severely impaired cognition and ability to express her needs and to understand others, impaired vision and moderate difficulties with hearing. According to MDS, Resident 38 had no verbal or physical behaviors directed toward others and had no behaviors of rejection of care. During the observations on 9/10/24 at 11:25 a.m. and 1:12 p.m., Resident 38 was sleeping in her bed and did not wake up when the Department attempted to talk to the resident. During the follow up observations on 9/11/24 at 8:22 a.m., 10:55 a.m., and 3:40 p.m., Resident 38 was observed sitting in wheelchair in her room. The resident was calm and laughed at times while constantly talking to herself. Resident 38 did not stop talking to self when the Department attempted to interview her. During an observation on 9/12/24 at 8:53 a.m., Resident 38 was up in her wheelchair, her eyes	F 758	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Assistant Director of Nursing (ADON) conducted an in-service with the licensed nurses on 9/27/24. The topic of this in-service was psychotropic medications, primarily covering indications and targeted behaviors. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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. A weekly psychotropic medication meeting will occur. The Social Services Director (SSD), Director of Nursing (DON), and Assistant Director of Nursing (ADON) all participate. In this meeting, every patient on psychotropic medication is reviewed to ensure that there is a proper manifestation, indication, and targeted association with each medication for the patient. The Medical Director, who is a psychiatrist, will also occasionally attend this weekly meeting. 2. This group of individuals will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality	

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F 758	Continued From page 52 were closed. Resident 38 was calm talking to herself and did not acknowledge anyone and did not respond to questions. During an observation on 9/13/24 at 12:50 p.m., accompanied by Director of Nursing (DON), the resident was sitting in wheelchair in her room. Resident was calm, smiled while talking to herself. The DON validated that the resident always talked to self. A review of Resident 38's physician note dated 7/23/24 at 5:59 p.m., indicated that the resident hallucinated and talked to herself but had no history of violence or suicide attempts. The physician documented that during the evaluation, the patient was turning her head from side to side and "engaging in conversation with herself", laughed at times, and appeared to be in pleasant mood. Physician's note did not contain any documentation that Resident 38 had aggressive behaviors of striking out and was at risk for self-harm or danger to others. The physician noted that the resident had no mental or psychiatric history prior to the progression of dementia and documented that Resident 38 had "dementia related psychosis." A review of the physician order dated 7/23/24, indicated the resident was started on Zyprexa (an antipsychotic medication to treat severe mental illness) 2.5 mg (milligram, unit of measurement) at bedtime for psychosis manifested by talking to self and paranoid statements. The physician directed staff to continue redirection and monitor episodes of talking to self and paranoid statements every shift.	F 758	Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/27/2024.	

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A review of the physician's note dated 7/30/24, at 10:06 p.m., indicated that facility's staff reported that Resident 38 "has been sedated and sleeping a lot in the daytime...not waking up fully for meals." The physician documented, "...today, the patient...appears sedated and sleepy on initial and repeat examination...awakes to voice briefly then goes back to sleep." The physician did not address Resident 38's behaviors and directed staff to hold antipsychotic medication if resident was sedated and missed meals due to sleepiness.

A review of Resident 38's care plan addressing the resident's antipsychotic medication Zyprexa initiated on 8/5/24 (over two weeks after the resident was started on antipsychotic medication), indicated that one of the interventions was to attempt non-pharmacological approaches prior to antipsychotic medication administration, which included assessing the resident for the presence of pain/discomfort, providing quiet and dark environment, keeping resident comfortable, offering warm beverages, etc.

A review of Resident 38's medication administration records (MAR's) from 7/23/24 through 9/12/24 indicated that the resident had been given Zyprexa every evening. There was no documented evidence that the facility attempted non-pharmacological interventions as directed in the Resident 38's care plan.

During an interview on 9/11/24 at 3:24 p.m., Licensed Nurse (LN 1) stated that he was familiar with Resident 38. LN 1 described the resident as very confused who talked to herself a lot. LN 1

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added, "[she] talks like there is another person next to her." LN 1 stated that talking to herself were the symptoms that the resident's was monitored for every shift and denied that the resident had aggressive behavior or was dangerous to herself or others.

During an interview in resident's room on 9/12/24 at 8:59 a.m., Certified Nursing Assistant (CNA 3) acknowledged that it was normal for Resident 38 to be talking to herself and added, "She just talks and talks all day long...Not dangerous to herself and to others."

During an interview with LN 2 on 9/12/24 at 9:10 a.m., LN 2 stated, "I have not seen her aggressive; she is talking to herself, having a whole conversation to herself like someone else is here." LN 2 explained that Resident 38 could not see and could not hear well and in order for the resident's cooperation, the staff needed "to call" for resident's attention before providing the care and explain what they were planning to do.

During an interview and concurrent record review on 9/12/24 at 9:25 a.m., the Assistant Director of Nursing (ADON) stated Resident 38 talked non-stop like she was having a conversation with her son. The ADON stated that Resident 38 was confused and was not able to verbalize her needs. The ADON stated that the resident was not aggressive, but occasionally could "get agitated and "hyper," and for these behaviors the physician prescribed the antipsychotic medication. Upon reviewing Resident 38's clinical record, the ADON validated that per nursing monitoring, the resident had anywhere from one to three episodes per shift of talking to herself,

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but was not able to locate any record indicating that the resident had aggressive behaviors and presented danger to self or others prior to start of Zyprexa. The ADON acknowledged that there was no documented evidence the staff checked if the resident had any physical needs and was not able to express them and there was no evidence the staff offered non-pharmacological behavioral interventions prior to administering antipsychotic medication to Resident 38 as directed in her care plan.

A review of the facility's policy titled, "Antipsychotic Medication Use," revised 2/2021, indicated, "Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicative and effective...The attending physician will identify, evaluate and document...symptoms that warrant the use of antipsychotic medications...Diagnoses alone do not warrant the use of antipsychotic medications...antipsychotic medications will...only be considered if the following conditions are also met: the behavioral symptoms present a danger to the resident or others; AND behavioral interventions have been attempted."

During an interview with DON on 9/13/24 at 10:20 a.m., the DON stated that the facility discussed new antipsychotic medications orders during quarterly Interdisciplinary (IDT) meetings. The DON explained that IDT reviewed if the antipsychotic medications were ordered for proper indication, manifestation, and appropriate dose. The DON stated that Resident 38's physician prescribed Zyprexa on 7/23/24 and the facility did not have chance to review if the

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psychotropic medication was prescribed properly and discuss resident's behaviors. The DON did not provide any answer when asked that by talking to herself and paranoid statements Resident 38 was at risk for harming herself or others. The DON stated that Resident 38's behavioral interventions including distraction and re-orientation should be implemented before administering Zyprexa.

During a telephone interview and concurrent record review with Pharmacy Consultant (PC) on 9/13/24 at 10:30 a.m., the PC stated that Resident 38 was started on antipsychotic medication recently. The PC was asked if Resident 38's talking to self and paranoid statements were indication of psychosis and presented danger to the resident or others. The PC stated, "No, talking to herself is not dangerous, but if resident is screaming and agitated it can affect her quality of life...it is hard to say whether resident's talking to herself related to dementia or psychosis." During a review of physician's progress notes addressing Resident 38's behaviors dated 7/23/24 and 7/30/24, the PC acknowledged that the notes did not contain documentation of Resident 38's violence, aggression, striking out, or at risk for self-harm or danger to others. The PC was asked if Zyprexa was recommended treatment for dementia related psychosis for geriatric residents and he replied, "If resident's symptoms are impeding their quality of life, [if the resident presents] danger to self or others. If resident does not have those symptoms, maybe its not for her. But its's too early to determine, [she is] not quite two months on it."

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A review of Lexicomp, a nationally recognized comprehensive drug reference that offers extensive warning and precautions of medications, indicated, "Antipsychotic agents, including olanzapine [Zyprexa], are not approved for the treatment of dementia-related psychosis." The Lexicomp indicated that prescribing Zyprexa for geriatric patients with dementia-related psychosis placed them at increased risk of dizziness, drowsiness, sedation, increased risk for falls and fractures, and death.

2. A review of Resident 150's Admission Record indicated Resident 150 was admitted in June 2024 with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and thinking skills) and dementia with behavioral disturbance. Resident 150's MDS, dated 6/25/24 indicated, severe cognitive impairment.

During a review of Resident 150's clinical record included the following documents:

A physician's order, dated 8/28/24, indicated an order for "risperidone (an antipsychotic), 1 mg (milligrams, a unit of measurement)/1 ml (milliliter, a unit of measurement) solution, Give 0.5 mg by mouth one time a day."

An MDS Section E, dated 6/25/24, indicated that Resident 150 had no potential indicators of psychosis.

During a review of Lexicomp (a nationally recognized drug information resource) indicated, "ALERT: US Boxed Warning...Risperidone is not approved for the treatment of patients with dementia-related psychosis."

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During a review of [manufacturer's name] full prescribing information for risperidone, the document indicated, "INDICATIONS AND USAGE...1.1 Schizophrenia (mental health condition that affects how people think, feel and behave)...1.2 Bipolar Mania (mental health condition causes extreme mood swing that include emotional highs)...1.3 Irritability Associated with Autistic Disorder (developmental disorder that impairs the ability to communicate and interact)..."

During an interview on 9/13/24 at 12:40 p.m. with Medical Director (MD), the MD stated that Resident 150's indication for use for risperidone was for BPSD (Behavioral and psychological symptoms of dementia).

During a concurrent interview and record review, on 9/12/24 starting at 2:00 p.m., with DON, the DON confirmed there was no target behavior in the physician's order and no indication for the risperidone 0.5mg dose. The DON further stated that Resident 150's indication was for mood disturbance manifested by striking out. DON stated it was her expectation that psychotropic medication orders included an indication and target behavior. The DON confirmed that the facility follows their policy on antipsychotic medication use and uses Food and Drug Administration (FDA) approved indications for antispyschotic medications.

During a review of the facility's policy titled, " Antipsychotic Medication Use," dated 2001, indicated under Policy Statement, "Antipsychotic medication shall be generally used only for the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 59 following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders. Item 9 indicated, "Diagnoses alone do not warrant the use of antipsychotic medication...in addition to the criteria, antipsychotic medications will generally only be considered if the following conditions are also met: the behavioral symptoms present a danger to the resident or others; AND: 1. The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity(unrealistic sense of being better)..."	F 758		
F 759 SS=E	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 the medication administration error rate was less than five percent (%) when two medication errors occurred out of 29 opportunities during medication administration for two residents (Resident 6 and Resident 71) of five selected residents during medication pass. This failure resulted in medications not given in accordance with the physician's orders and potential to affect the residents' clinical conditions.	F 759	F759 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice.	9/23/24

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F 759	Continued From page 60 Findings: A review of Resident 6's Admission Record, Resident 6 was admitted to the facility in early 2023 with admitting diagnosis of Type 2 Diabetes (a long term condition in which the body has trouble controlling sugar in the blood). Resident 6's Minimum Data Set (MDS, an assessment tool), dated 7/1/24 indicated, severe cognitive impairment. During a medication administration observation on 9/11/24 at 8:21 a.m., Licensed Nurse 2 (LN 2) was observed preparing to administer Resident 6's insulin aspart (rapid acting injectable medication for diabetes). During a medication administration observation on 9/11/24 at 8:30 a.m. LN 2 administered 2 units of insulin aspart to Resident 6. During an interview on 9/11/24 at 8:35 a.m. with LN 2, LN 2 stated Resident 6's blood sugar level was 154 mg/dl (unit of measure for weight/volume) prior to administration of insulin aspart. During a continued interview with LN 2 when asked how the dose of insulin for the administration was calculated, LN 2 responded based on Resident 6's blood sugar level of 154 mg/dl, the sliding scale insulin order (various units of insulin based on blood sugar levels) was used to calculate the dose. During a concurrent interview and observation on 9/11/24 at 8:40 a.m. with LN 2, the blood glucose machine indicated that Resident's 6 blood glucose was taken at 7:07 a.m. LN 2 confirmed that blood glucose was taken prior to eating	F 759	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Director of Nursing (DON) conducted a series of in-services for the licensed nurses on 9/11/24, 9/12/24, and 9/23/24 on medication administration. The in-services covered the administration of medication in accordance with physician□s orders. The in-services on 9/11 specifically covered following physician□s orders for insulin administration. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 pharmacist representative will attend the quarterly Quality Assurance meeting. In this meeting, he will report on any medication errors found. This monitoring process will take place over the course of this quarter and continue as the QAPI committee feels is necessary. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/23/2024	

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F 759	Continued From page 61	F 759		

breakfast. LN 2 confirmed that Resident 6 had already eaten breakfast. LN 2 further stated that Resident 6 refused insulin earlier in the morning. LN 2 confirmed that there was no documented evidence that Resident 6 refused insulin.

During a review of Resident's 6's Physician Orders, Resident 6's current Physician Orders indicated, "Novolog insulin [insulin aspart] 100 u/ml [units/milliliter, unit of measure] Inject per sliding scale:] 150-199=2 units, 200-249=3 units, 250-299=6 units, 300-349=9 units, 400-450=12 units, Notify MD [Medical Doctor] for DM [Diabetes Mellitus, a condition where the body does not metabolize sugar] subcutaneous [under the skin]."

During an interview on 9/11/24 at 2:40 p.m. with the Director of Nursing (DON), the DON stated her expectation is the LN to check blood glucose prior to administering insulin and administer insulin 15-30 minutes before the meal is served. DON further stated, "If the medication is missed or insulin has not been given per doctor's order, the LN should have called the doctor to communicate the situation."

During a review of facility's policy and procedure titled, "Insulin Administration," revised September 2014, indicated, "The type of insulin, dosage requirements, strength and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician order." The facility policy further indicated "1. Notify your supervisor if the resident refuses the insulin."

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F 759	Continued From page 62 2. A review of Resident 71's Admission record, Resident 71 was admitted to the facility in late 2022 with admitting diagnoses which included anemia (low levels of healthy red blood cells). Resident 71's MDS, dated 6/17/24 indicated, severe cognitive impairment. During a medication observation on 9/11/24 at 8:44a.m. in station one with LN 1, LN 1 was observed to prepare and administer Resident 71's morning medications which did not include an order for folic acid. During a review of Resident's 71's Physician Orders, the current Physician Orders indicated an order dated 9/21/23 for folic acid one mg (milligram, unit of measure for weight) tablet give 1 mg by mouth in the morning. During an interview on 9/11/24 at 8:35 a.m. with LN 1, LN 1 stated Resident 6's folic acid was not in the medication cart. LN 1 further stated that the medication would need to be followed up with the pharmacy. LN 1 was unable to explain why Resident's 6 folic acid was not available. During an interview on 9/11/24 at 2:40 p.m. with the DON, the DON stated that if a medication is not available the LN should call the pharmacy and see why the medication was not delivered. During a review of facility policy and procedure titled, "Administering Medications," last revised April 2019, indicated "Medications are administered...as prescribed...Medications are administered in accordance with prescribers orders..."	F 759		
F 760	Residents are Free of Significant Med Errors	F 760		9/14/24

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F 760 SS=E	Continued From page 63 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 observation, interview and record review, the facility failed to ensure one of 5 selected residents during medication pass (Resident 6) was free of significant medication errors when a licensed nurse administered insulin aspart, (short acting injectable medication used to lower blood sugar level) not in accordance with physician orders. This failure put the resident at risk for suffering adverse consequences from the medication. Findings: A review of Resident 6's Admission Record, Resident 6 was admitted to the facility in early 2023 with admitting diagnosis of Type 2 Diabetes (a long term condition in which the body has trouble controlling sugar in the blood). Resident 6's Minimum Data Set (MDS, an assessment tool), dated 7/1/24 indicated, severe cognitive impairment. During a medication administration observation on 9/11/24 at 8:21 a.m., Licensed Nurse 2 (LN 2) was observed preparing to administer Resident 6's insulin aspart. During a medication administration observation on 9/11/24 at 8:30 a.m. LN 2 administered 2 units of insulin aspart to Resident 6.	F 760	F760 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Director of Nursing (DON) conducted an in-service for the licensed nurses on 9/11/24 on medication administration in accordance with physician's orders, specifically insulin administration. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action	

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F 760	Continued From page 64 During an interview on 9/11/24 at 8:35 a.m. with LN 2, LN 2 stated Resident 6's blood sugar level was 154 mg/dl (unit of measure for weight/volume) prior to administration of insulin aspart. During a continued interview with LN 2 when asked how the dose of insulin for the administration was calculated, LN 2 responded based on Resident 6's blood sugar level of 154 mg/dl, the sliding scale insulin order (various units of insulin based on blood sugar levels) was used to calculate the dose. During a concurrent interview and observation on 9/11/24 at 8:40 a.m. with LN 2, the blood glucose machine indicated that Resident's 6 blood glucose was taken at 7:07 a.m. LN 2 confirmed that blood glucose was taken prior to eating breakfast. LN 2 confirmed that Resident 6 had already eaten breakfast. LN 2 further stated that Resident 6 refused insulin earlier in the morning. LN 2 confirmed that there was no documented evidence that Resident 6 refused insulin. During a review of Resident's 6's Physician Orders, Resident 6's current Physician Orders indicated, "Novolog insulin [insulin aspart] 100 u/ml [units/milliliter, unit of measure] Inject per sliding scale:] 150-199=2 units, 200-249=3 units, 250-299=6 units, 300-349=9 units, 400-450=12 units, Notify MD [Medical Doctor] for DM [Diabetes Mellitus, a condition where the body does not metabolize sugar] subcutaneous [under the skin]." During an interview on 9/11/24 at 2:40 p.m. with the Director of Nursing (DON), the DON stated her expectation is the LN to check blood glucose	F 760	evaluated for its effectiveness. The POC must be integrated into the quality assurance system; 1. The pharmacist representative will attend the quarterly Quality Assurance meeting. In this meeting, he will report on any medication errors found. This monitoring process will take place over the course of this quarter and continue as the QAPI committee feels is necessary. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/14/2024	

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F 760	Continued From page 65 prior to administering insulin and administer insulin 15-30 minutes before the meal is served. DON further stated, "If the medication is missed or insulin has not been given per doctor's order, the LN should have called the doctor to communicate the situation." During a review of the Institute for Safe Medication Practices (ISMP), updated in 2017, "insulins, all formulations and strengths are considered to be high-alert medications." During a review of facility's policy and procedure titled, "Insulin Administration," revised September 2014, indicated, "The type of insulin, dosage requirements, strength and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician order." The facility policy further indicated "1. Notify your supervisor if the resident refuses the insulin."	F 760		
F 761 SS=E	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	F 761		9/23/24

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F 761	Continued From page 66 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 medications were properly stored and labeled, when: 1. Medications were not properly stored per manufacturer instruction, 2. Expired and discontinued medications were available for resident use, 3. Loose pills and loose medical supplies were found in the drawers and the back of medication cart and 4. Refrigerated medications were not stored in accordance with facility Policy & Procedure (P&P). These deficient practices had the potential for residents to receive medications with unsafe or reduced potency from being used past their expiration date or improper storage, and diversion or misuse of medications from not being securely stored. Findings:	F 761	F761 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Infection Preventionist Nurse (IP) conducted an in-service for the licensed nurses on 9/19/24. This in-service covered organization and sanitizing of the medication cart. 2. The Director of Nursing (DON)	

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F 761	Continued From page 67 1. During an inspection of medication cart B on 9/10/24 at 11:00 a.m. alongside Licensed Nurse 4 (LN 4), a bottle of Acidophilus (a supplement that promotes the growth of good bacteria) was found stored in the medication cart. LN 4 confirmed the finding and stated the medication should be stored in the refrigerator after opening. During review of the facility's P&P titled, "Medication Storage in the Facility," dated March 2018, the P&P indicated, "Medications requiring "refrigeration"...are kept in a refrigerator..." 2. During an ongoing inspection of Medication Cart B on 9/10/24 starting at 11:10 a.m. with LN 4, one bottle of erythromycin (antibiotic ointment) labeled with an open date of 8/15/24 with a stop order date of 7 days was identified. LN 4 stated that the medication should have been removed from the medication cart. LN 4 confirmed the finding and stated that the order was completed and discontinued. During an ongoing inspection of Medication Cart B on 9/10/24 starting at 11:15 a.m. with LN 4, Arformoterol nebulizer treatments (medication to treat breathing problems) with a fill date of 6/26/24 was identified. LN 4 confirmed that the facility uses manufacturer's expiration date and that the medication should have been discarded 6 weeks after 6/26/24. During an interview on 9/11/24 at 2:40 p.m. with Director of Nursing (DON), the DON stated expired medications were to be removed from the facility's supply and placed in the locked medication destruction cabinet located in the medication storage room to be logged and	F 761	conducted an in-service for the licensed nurses on 9/23/24 on medication storage and destruction. In this in-service, the nurses were also reminded that they are responsible to check that the proper meds are in stock in the cart, there are no loose pills in the cart, and that medication is destroyed properly. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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. There is a weekly check on each nursing cart that will occur to ensure there are no loose pills, missing medication, and that medication is disposed of properly. This process is monitored by the Assistant Director of Nursing (ADON) as well as the Director of Nursing (DON). These two department heads will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/23/2024	

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F 761	Continued From page 68 disposed. During a review of "[name of pharmacy] Nebulizer Medication Expiration Dates", dated 10/2022 the document indicated, "Arformoterol...unopened foil pouch at room temp up to 6 weeks." During review of the facility's P&P titled, "Medication Storage in the Facility," dated March 2018, the P&P indicated, "Procedures...M. Outdated, contaminated, deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...and reordered from the pharmacy...if a current order exists...12. "Drugs shall not be kept in stock after the expiration date on the label...14. Discontinued drug containers shall be marked, or otherwise identified, to indicate that the drug has been discontinued, or shall be stored in a separate location which shall be identified solely for this purpose..." 3. During ongoing inspection of Medication Cart B on 9/10/24 starting at 11:20 a.m. with LN 4, loose pills were found in medication cart B. LN 4 verified there were 6 loose pills in the medication cart. During ongoing inspection of Medication Cart B on 9/10/24 starting at 11:25 a.m. with LN 4, loose medical supplies were found behind the medication drawers. LN 4 verified there were syringes at the back of the medication cart. During review of the facility's P&P titled,	F 761		

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F 761	Continued From page 69	F 761		

"Medication Storage in the Facility," dated March 2018, the P&P indicated,"...Medications are stored properly...to maintain their integrity and to support safe effective drug administration...Medication storage should be kept clean, well lit, organized and free of clutter..."

4. During an inspection of the Medication Storage Room 2 refrigerator on 9/10/24 at 10:50 a.m. alongside LN 3, the temperature was observed at 51 degrees Fahrenheit (a unit of measurement). LN 3 confirmed the finding and stated the refrigerator temperature was to be maintained between 36 to 46 degrees. No medications were stored in the refrigerator at time of inspection.

During an inspection of the Medication Storage Room 2 refrigerator on 9/11/24 at 3:26 p.m., alongside with the Unit Manager (UM). The temperature was observed still out of range, at 29 degrees Fahrenheit. Medications were observed in the refrigerator at time of reinspection. UM confirmed the finding and stated it was out of range and that maintenance would need to be notified.

During a concurrent observation and interview on 9/11/24 at 3:30 p.m., with UM, the UM acknowledged and confirmed that all the insulin stored in the refrigerator were frozen. UM stated that because the temperature was too cold, the composition of the medication would change and further stated that the medication would not be safe to administer to the residents.

During a review of the facility's P&P titled, "Medication Storage at the Facility," dated March

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F 761	Continued From page 70 2018, the P&P indicated, "Procedures... K. Medications requiring 'refrigeration' or 'temperatures between...36 degrees Fahrenheit...and 46 degrees Fahrenheit are kept in a refrigerator with a thermometer to allow temperature monitoring...6. Drugs requiring refrigeration shall be stored in a refrigerator between...36 degrees Fahrenheit...and 46 degrees Fahrenheit..."	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 food storage, service and distribution were not completed in accordance with professional standards when:	F 812	F812 How corrective action(s) will be accomplished for those residents found to have	9/30/24

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NORTH POINTE CARE CENTER	500 JESSIE AVENUE SACRAMENTO, CA 95838

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 71 1. Kitchen vents, fans, and floors were found dirty and/or dusty, 2. Worn food preparation equipment was kept in storage and not discarded when it could no longer be sanitized, 3. Foods in storage found expired, open to the environment, and/or improperly labeled, and 4. Kitchen staff were unable to demonstrate how to test for proper sanitation concentration levels. These failures had the potential to cause food borne illness for the 155 residents receiving facility prepared foods. Findings: 1a.) During the initial kitchen observation on 9/10/24 at 9:01 a.m., the vents in the kitchen ceiling had whitish-gray build-up on the ventilation slats (where air exists the heating and air conditioning unit). 1b.) During the initial tour and on follow up visits on 9/10/24, fans in the kitchen had visible build-up of dirt/dust. 1c.) During an inspection of the storage room on 9/10/24 at 9:40 a.m., there were white pieces of paper scattered on the floor, covering 1 by 2 feet. 1d.) During an inspection of the walk-in refrigerator and walk-in freezer on 9/10/24 at 9:58 a.m., the refrigerator floor appeared dirty, with red splatters of approximately 1 inch in diameter covering a 2 by 3 feet area and the walk-in freezer floors were discolored.	F 812	been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The Registered Dietician (RD) conducted an in-service for the dietary staff on 9/30/24. The topics covered in this in-service were the discard of damaged equipment, food storage/proper labeling, and how to test for proper sanitation concentration levels. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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. There is a weekly cleaning schedule to maintain compliance with these items. 2. In-services will be conducted by the RD as needed in accordance with the department□s performance. 3. This process will be monitored by the RD and the Dietary Manager will identify, track, and trend the root cause of any	

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F 812	Continued From page 72 During a follow up visit to the kitchen for observation and interview on 9/10/24 at 4:23 p.m. with the Dietary Assistant Manager (DA), the DA acknowledged the storage room floor had pieces of paper scattered on the floor. The DA acknowledged this was a problem and needed to be cleaned. During a concurrent observation and interview with the DA on 9/10/24 at 4:25 p.m., The DA acknowledged the refrigerator had splatters of food substance on the floor. Furthermore, during an interview with the Registered Dietitian (RD) on 9/11/24 at 3:36 p.m., the RD acknowledged the freezer floors were dirty on 9/10/24, and stated that she had to remind staff to clean the floors throughout the shift to maintain cleanliness. During a concurrent observation and interview on 9/10/24 at 4:28 p.m. with the DA, the DA acknowledged the fans and ceiling vents had dirt/dust build-up present. The DA stated that the dirt/dust could get on the food and clean plates. The DA stated that the fans and ceiling vents were scheduled to be cleaned every two weeks "...if there are available hours to schedule another staff to be able to clean them." The DA and RD further acknowledged that the freezer floors were discolored, and that maintenance would need to be notified. In a follow-up interview with the RD on 9/11/24 at 3:36 p.m., the RD stated that it was her expectation that staff clean and sanitize the kitchen to prevent cross-contamination. A review of the facility's Policy and Procedure (P&P) titled "Sanitation", dated 2023 indicated,	F 812	ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/30/2024.	

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F 812	Continued From page 73 "All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped areas." A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section 6-501.14 titled, "Cleaning Ventilation Systems, Nuisance and Discharge Prohibition." Indicated, (A) "Intake and exhaust air ducts shall be cleaned, and filters changed so they are not a source of contamination by dust, dirt, and other materials." A review of the US FDA 2022 Food Code, section 4-601.11, titled "Cleaning of Equipment and Utensils" indicated "NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." A review of the US FDA 2022 Food Code, section 4-601.11, titled, "Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils" indicated, "The objective of cleaning focuses on the need to remove organic matter from food contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted." 2. During the initial kitchen observation on 9/10/24 at 9:01 a.m., worn food preparation equipment was kept in the storage room and not discarded when it could no longer be sanitized.	F 812		

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F 812	Continued From page 74	F 812		

During observation and interview on 9/10/24 at 9:40 a.m., the storage room had a strainer with rust, a brown cutting board with a warped appearance and deep gouges, and a warped plastic container. The DA acknowledged the damaged food container, cutting board and rusty strainer. The DA stated they needed to be thrown away and/or replaced because they could not be properly sanitized.

A review of the facility's P&P titled; "Sanitation", dated 2023 indicated, "All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped areas."

A review of the US FDA 2022 Food Codes, section 4-501.12 "Cutting Surfaces" indicated, "Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED, or discarded if they are not capable of being resurfaced." Section 4-202.11 "Food-Contact Surfaces", indicated "Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections."

3. During the initial tour in the dry storage room on 9/10/24 at 10:05 a.m., a previously opened zip lock bag containing coconut flakes and a previously opened zip lock bag containing chocolate chips were not re-sealed properly. The DA stated that the zip lock bags should be closed as "bugs and other things could get into it ...not safe for residents". Furthermore, three and 1/2

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F 812	Continued From page 75	F 812		

bags of tortilla chips were on the shelf that expired on "7/24", four nectar juices expired on "3/24", and one bag of opened "Ruffles" potato chips was also found that had a label that was dated "9/9", with no year present on label. The DA stated that labels should have the complete date, including the year.

A review of the US FDA 2022 Food Code, section 3-202.15, titled "Package Integrity" indicated, "FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants."

A review of the US FDA 2022 Food Code, section 3-501.17 (A) (B) (C) (D) indicated that, "...the day the original container is opened in the food establishment shall be counted as Day 1...The date marked shall not exceed a manufacturer's use-by date...with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises..."

4. During the initial kitchen observation on 9/10/24 at 10:25 a.m., in the dishwashing area, Dietary Staff 1 (DS 1) was asked to demonstrate how to test for proper sanitation concentration levels of the red bucket. DS 1 held test strip in the solution for 10 seconds. Directions on the test strip bottle stated to hold the test strip in the solution for five seconds.

During a follow up visit to the kitchen on 9/10/24 at 4:15 p.m., DS 2 was asked to test for proper sanitation concentration levels and was not able to. At 4:19 p.m., the DA demonstrated the test strip procedure and left test strip in the solution

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F 812	Continued From page 76 for 10 seconds. The DA acknowledged that the directions on the test strip bottle stated to hold the test strip in the solution for five seconds. Furthermore, during an interview with the RD on 9/11/24 at 3:36 p.m., the RD stated that all staff should know how to test for sanitation to "prevent cross-contamination" and to "prevent food-borne illness". During a follow up kitchen observation on 9/11/24 at 9:35 a.m., DS 3 was observed wiping tray carts with a 1-step cleaning product. DS 3 sprayed the 1-step solution on cart (inside and out) and immediately wiped down the cart. Review of the Directions for the 1-step cleaning solution (One Step | CUI Solutions) indicated to: Apply solution with a mop, cloth, sponge, hand pump trigger sprayer or low pressure coarse sprayer so as to wet all surfaces thoroughly. Allow to remain wet for 10 minutes, then remove excess liquid. A review of the facility's Policy and Procedure (P&P) titled; "Sanitation", dated 2023 indicated, "...Each employee shall know how to operate and clean all equipment in his specific work areas."	F 812		
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.	F 880		9/26/24

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F 880	Continued From page 77 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 78 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 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 ensure infection prevention and control measures were maintained when: 1. Certified Nursing Assistant (CNA) 6 did not perform hand hygiene when feeding multiple residents during lunch; 2. Resident 20's nasal cannula (a thin flexible tube with two prongs that go inside the nostrils to deliver oxygen) and nebulizer (a small machine that turns liquid medicines into mist to deliver medications directly into the lungs) mask were not dated and stored in a sanitary manner; 3. CNA 2 did not perform hand hygiene when	F 880	F880 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice	

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F 880	Continued From page 79 delivering lunch trays; and 4. Food items and nail clippers were improperly stored inside the medication carts. These failures had the potential to result in the spread of infection in the facility. Findings: 1. During the dining observation on 9/10/24 at 12:07 p.m. in Wanderhall Dining Room, CNA 6 was feeding Resident 44 lunch with a spoon. At 12:11 p.m., CNA 6 finished feeding Resident 44, then moved on to feed Resident 35. At 12:26 p.m., CNA 6 finished feeding Resident 35, then put two empty lunch trays back to the lunch cart that was parked in the hallway. CNA 6 came back to the dining room, started feeding Resident 130. At 12:30 p.m., CNA 6 put away more empty lunch trays, then came back to the dining room to remove Resident 44's clothing protector. At 12:32 p.m., CNA 6 came out of the dining room, went to a medication cart in the hallway and took a plastic spoon from the cart. At 12:36 p.m., CNA 6 started feeding Resident 21. At 12:40 p.m., CNA 6 pushed Resident 44 back to the hallway and placed her outside of her room. CNA 6 did not perform proper hand hygiene between residents and between the tasks observed. During an interview on 9/10/24 at 12:48 p.m. with CNA 6, when asked if she performed hand hygiene between residents when assisting them	F 880	does not reoccur; 1. A series of in-services were conducted by the Director of Staff Development (DSD), Director of Nursing (DON), as well as the Infection Preventionist Nurse (IP) on infection control measure. The dates of these in-services were 9/10, 9/11, 9/18, 9/19, 9/20, and 9/26. The topics in these in-services are as follows: a. Hand hygiene when feeding b. Dating and storage of respiratory devices c. Hand hygiene when delivering lunch trays d. Improper storage of nail clippers and food in carts. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 DSD, IP, and DON will identify, track, and trend the root cause of any ongoing noncompliance and implement further changes of measures, as necessary. Any concerns will be addressed at the monthly Quality Assurance meeting. 2. In-services will be conducted to maintain compliance with these issues. Include dates when corrective action will be completed. The corrective action	

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F 880	Continued From page 80 with their lunch, CNA 6 stated she used the wipes in a green bag. Then she showed the Department which wipes she used. During an interview on 9/10/24 at 12:56 p.m. with the Director of Staff Development (DSD), the DSD confirmed the wet wipes that CNA 6 used did not have sanitary purpose, it was used for peri care. The DSD stated staff should use hand sanitizer or hand sanitizer wipes for hand hygiene. The DSD further stated staff should not use the wet wipes to clean their hands between tasks. During an interview on 9/10/24 at 1:02 p.m. with CNA 6, CNA 6 confirmed she did not perform proper hand hygiene between residents, and stated she should have cleaned her hands with hand sanitizer to prevent spreading infection. During an interview on 9/12/24 at 11:26 a.m. with the DSD, the DSD stated all CNAs received hand hygiene training, the facility provide training multiple times throughout the year, all staff demonstrated proper hand washing. During an interview on 9/12/24 at 1:14 p.m. with the Infection Preventionist (IP), the IP stated hand hygiene should be performed before and after tasks, before entering and after leaving a resident's room, and had to be performed between residents during feeding. The proper way of hand hygiene included washing hands with soap and water or using hand sanitizer. Wet wipes were not to be used for hand hygiene. During a review of the facility's policy and procedure (P&P) titled, "Hand washing/Hand	F 880	completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 9/26/2024	

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F 880	Continued From page 81	F 880		

Hygiene", revised 10/2023, the P&P indicated, "Indication for Hand Hygiene 1. Hand Hygiene is indicated: a. immediately before touching a resident;...d. after touching a resident; e. after touching the resident's environment;...2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations."
2. A review of Resident 20's clinical record indicated she was admitted on 6/24/24 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD, a lung disease causing breathing problems).

Further review of Resident 20's clinical record indicated physician orders, dated 8/13/24, to change the nasal cannula every Thursday and a solution to inhale by mouth via nebulizer three times a day for COPD.

During an observation on 9/10/24 starting at 9:29 a.m., Resident 20 was lying in bed with eyes closed with ongoing oxygen via nasal cannula attached to a concentrator (device that takes air from the surroundings, filters it and gives extra oxygen). Resident 20's bedside drawer was halfway open and there was a face mask attached to a nebulizer. Resident 20 had a wheelchair near the foot of the bed and a nasal cannula was on top of the wheelchair seat attached to a small oxygen tank. The two nasal cannulas and nebulizer mask were not labeled, the nebulizer mask and the nasal cannula on top of the wheelchair were not covered.

In a concurrent observation and interview on 9/10/24 at 9:44 a.m., the CNA 1 stated Resident 20 uses oxygen 24 hours a day, 7 days a week and the nasal cannula in the wheelchair was

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F 880	Continued From page 82	F 880		

used by Resident 20 when she goes out of her room. The CNA 1 further stated Resident 20 had been using the nebulizer. The CNA 1 confirmed the two nasal cannula and the nebulizer mask were not labeled. The CNA 1 further confirmed the nasal cannula in the wheelchair and the nebulizer mask had no cover.

In a concurrent observation and interview on 9/10/24 at 10:07 a.m., the Unit Manager (UM) stated the oxygen tubing and the nebulizer mask should be dated and bagged. The UM further stated the oxygen tubing and the nebulizer mask should be labeled once it was changed.

In an interview on 9/12/24 at 1:14 p.m., the IP stated the nasal cannula and nebulizer mask should be covered in a bag. The IP further stated the staff should take care of the tubing and mask to prevent the germs from getting into the equipment.

In an interview on 9/13/24 at 10:49 a.m., the Director of Nursing (DON) stated her expectation was for the nebulizer mask to be labeled and changed every 7 days. The DON further stated the nasal cannula and nebulizer mask should be in a bag if it was not being used.

In a follow up interview and record review on 9/13/24 at 11:11 a.m., the DON stated there should be an order for the nebulizer mask to be changed every 7 days. The DON reviewed Resident 20's physician's orders and she confirmed there was no order to change the nebulizer mask.

There was no documented evidence the

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nebulizer mask and tubing for Resident 20 was changed since 8/13/24.

A review of the facility's policy and procedure revised November 2011 and titled, "Departmental (Respiratory Therapy) - Prevention of Infection" indicated, "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment...among residents and staff... Infection Control Considerations Related to Oxygen Administration...Change the oxygen cannulae and tubing every seven (7) days, or as needed...Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use...Infection Control Considerations Related to Medication Nebulizers...Store the circuit in plastic bag, marked with date and resident's name, between uses...Discard the administration "set-up" every seven (7) days."

3. During a lunch meal observation on 9/10/24 starting at 12:03 p.m., the CNA 2 entered room 48 holding a meal tray. The CNA 2 adjusted the wheelchair of the resident in room 48 C before setting up the tray. The CNA 2 came out of the room at 12:04 p.m., then CNA 2 took out a meal tray from the cart located in the hallway and delivered the tray in room 49. The CNA 2 did not perform hand hygiene after exiting the room or before taking the meal tray.

In an interview on 9/10/24 at 12:45 p.m., the CNA 2 confirmed she touched the wheelchair and set the meal tray for resident in room 48 C. The CNA 2 stated she did not remember if she used hand sanitizer after she helped resident in room 48

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and before getting the meal tray for another resident. The CNA 2 further stated she should have washed or sanitized her hands in between residents.

In an interview on 9/12/24 at 1:14 p.m., the IP stated hand hygiene should be performed before and after tasks, before entering the room and after leaving the room.

A review of the facility's P&P revised October 2023 and titled, "Handwashing/Hand Hygiene" indicated, "This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections... All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents...Hand hygiene is indicated...after touching a resident...after touching the resident's environment..."

4. During a concurrent inspection of medication cart B and interview on 9/10/24 at 11:00 a.m. with Licensed Nurse (LN) 4, food items (a sandwich and an opened pudding) were found stored in the medication cart. LN 4 confirmed the finding and stated the food items should not be stored in the medication cart. LN 4 acknowledged that medication carts should only be used for medications.

During a concurrent inspection of medication cart B and interview on 9/10/24 at 11:05 a.m. with LN 4, 3 nail clippers were identified and stored next to eyedrops. LN 4 confirmed the finding and stated that the nail clippers "should" be clean. LN 4 acknowledged that medication carts should only be used for medications.

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F 880	Continued From page 85 During an interview on 9/11/24 at 2:40 p.m. with the DON, the DON stated all food items should be in the ice bucket on top of the medication cart. DON further stated that nail clippers should not be stored in medication carts due to sanitary concerns. During review of the facility's P&P titled, "Medication Storage in the Facility," dated March 2018, the P&P indicated, "Medication storage areas are kept clean..."	F 880		
F 911 SS=B	Bedroom Number of Residents CFR(s): 483.90(e)(1)(i) §483.90 (e)(1) Bedrooms must §483.90(e)(1)(i) Accommodate no more than four residents. For facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, six of 53 resident rooms (room 15, 16, 22, 23, 24, and 25) accommodated more than four residents in each room. Findings: During a review of the facility's 'Approval of Program Flexibility for FLEX -7612' letter, dated 2/25/2024, provided by the Administrator (ADM), the letter indicated that two rooms (Rooms 15 and 16) had six beds each and rooms 22, 23, 24, and 25 had five beds each. The letter indicated,	F 911	F911 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice.	10/4/24

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F 911	Continued From page 86 "Even though we will have more beds in the rooms, the staffing ratio will continue to be scheduled based on patient acuity ...there will be no decline the amount of care or attention the patients are receiving." During a review of the facility's census, dated 9/9/2024, the census indicated Room 15, 16, 22, 23, 24, and 25 had more than four beds in each room. During a tour of the facility on 9/10/24, commencing at 9:10 a.m., multiple observations of the rooms containing more than 4 residents per room were made. Each of the beds had a privacy curtain to separate the residents when the care was provided. The residents were able to move in and out of the rooms, and there was space for beds, side tables, and residents' care equipment. During a concurrent observation and interview with Certified Nursing Assistant 8 (CNA 8) on 9/11/24 at 9:15 a.m., CNA 8 stated there was sufficient space in room 15 to provide resident's care care and respond to emergencies. CNA 8 stated the residents were all ambulatory with minimal or stand-by assist and none of the residents required mechanical lifting machine. CNA 8 stated there have been five residents in room 15 for a while and there has never been a problem when there were six residents. During an interview on 9/11/24 at 3:10 p.m., CNA 9 stated he had been assigned to room 15 for several years. CNA 9 stated all five residents residing in room 15 were ambulatory and some of them required assistance. CNA 9 stated there	F 911	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur; 1. The facility obtained a flex waiver. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 administrator will renew the flex room waiver as needed. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 2/26/2024.	

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were no concerns with space and there was enough room to accommodate a mechanical lift if needed.

During an interview with Licensed Nurse 1 (LN 1) on 9/11/24 commencing at 3:20 p.m., LN 1 stated he was frequently assigned to rooms 22, 23, 24, and 25. LN 1 stated rooms 22, 23, 24, and 25 had enough space for residents and the staff to assist and work with the residents. LN 1 further stated rooms 22, 23, 24, and 25 had adequate space to properly maneuver resident's assistive devices, store the residents' personal belongings, and to provide privacy to the residents during care.

During an interview on 9/11/24 at 3:55 p.m., with Responsible Party (RP 2) for Resident 150 residing in room 15, the RP 2 stated she visited her husband frequently. The RP 2 stated, "A lot of patients here and can be noisy at times, especially if a few of them start yelling or become agitated ...but they have their privacy and curtains separating them." The RP 2 stated she did not think there was concern with space.

During an interview with LN 8 on 9/11/24 at 4:51 p.m., LN 8 stated there was sufficient space in rooms 15 and 16 to give nursing care and respond to emergencies.

During an interview with CNA 10 on 9/12/24 at 9:25 a.m., CNA 10 stated she had been assigned to provide care for residents in room 16 frequently. CNA 10 stated there was enough space for five residents' beds and wheelchairs. CNA 10 stated currently none of the residents required a mechanical lift, but if needed, the staff

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F 911	Continued From page 88 were able to maneuver it. CNA 10 stated there were no complaints from residents' families regarding the space. During an interview with Maintenance Supervisor (MS) on 9/12/24 at 4:15 p.m., the MS stated there were no concerns with space in rooms 15, 16, 22, 23, 24, and 25. The room waiver is recommended for continuation per facility request, as contingent upon compliance with federal regulations at Resident Rights (483.10) and Physical Environment (483.90).	F 911		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation and interview, two of 53 resident rooms (15 and 16) did not meet the minimum requirement of 80 square feet (sq ft; unit of measurement) per resident. Findings: During a tour of the facility on 9/11/24, commencing at 9:10 a.m., the observations were made and the rooms 15 and 16 were observed to have six beds in each of the rooms. During an observation, the rooms were uncluttered, residents were able to move in and out of the rooms, and there was space for beds, wheelchairs, side tables, and other residents' care equipment.	F 912	F912 How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will	10/4/24

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F 912	Continued From page 89 During a concurrent observation and interview with Certified Nursing Assistant (CNA 8) on 9/11/24 at 9:15 a.m., CNA 8 stated there was sufficient space in room 15 to give personal care and respond to emergencies. CNA 8 stated the residents were all ambulatory with minimal or stand-by assist and none of the residents required a mechanical lift machine. During an interview on 9/11/24 at 3:10 p.m., CNA 9 stated he had been assigned to room 15 for several years. CNA 9 stated all five residents residing in room 15 were ambulatory, some residents required assistance. CNA 9 stated there were no concerns with space and there was enough room to accommodate a mechanical lift if needed. During an interview on 9/11/24 at 3:55 p.m., with Responsible Party (RP 2) for Resident 150 residing in room 15, RP 2stated she visited her husband frequently. RP 2 stated, "A lot of patients here and can be noisy at times, especially if a few of them start yelling or become agitated ...but they have their privacy and curtains separating them." The RP 2 stated she did not think there was concern with space. During an interview with Licensed Nurse (LN 8) on 9/11/24 at 4:51 p.m., LN 8 stated there was sufficient space in rooms 15 and 16 to give nursing care and respond to emergencies. During an interview with CNA 10 on 9/12/24 at 9:25 a.m., CNA 10 stated she had been assigned to provide care for residents in room 16 frequently. CNA 10 stated there was enough	F 912	make to ensure that the deficient practice does not reoccur; 1. The facility obtained a flex waiver. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that 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 administrator will renew the flex room waiver as needed. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Survey Agency. The facility is in compliance as of 2/26/2024.	

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F 912	Continued From page 90	F 912		

space for five residents' beds and wheelchairs. CNA 10 stated currently none of the residents required mechanical lift, but if needed, the staff were able to maneuver it. CNA 10 stated there were no complaints from residents' families regarding the space.

During an interview with Maintenance Supervisor (MS) on 9/12/24 at 4:15 p.m., a usable living space for each resident in rooms 15 and 16 was calculated. Rooms 15 and 16 measured 70.56 sq ft per resident. The MS acknowledged that both rooms were below the minimum requirement of 80 square feet per resident.

During a review of the facility's 'Approval of Program Flexibility for FLEX -7612' letter, dated 2/25/2024, provided by the Administrator (ADM), the letter indicated that two rooms (Rooms 15 and 16) had six beds each and rooms 22, 23, 24, and 25 had five beds each. The letter indicated, "Even though we will have more beds in the rooms, the staffing ratio will continue to be scheduled based on patient acuity ...there will be no decline the amount of care or attention the patients are receiving."

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