STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 08/29/2024

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 08/25/24 through 08/29/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #315B11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 08/25/24 through 08/29/24. Event ID# 315B11. The following intakes were investigated NC00221144, NC00220505, NC00219048, NC00218191, NC00218196, NC00217376, NC00216857, NC00216654, NC00215919, and NC00210261. 2 of the 25 complaint allegations resulted in deficiency.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		

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

Electronically Signed | 09/16/2024

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F 607	Continued From page 1 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy for staff to immediately report an allegation of resident-to-resident abuse to the facility management as soon as the incident was observed. This occurred for 2 of 6 residents (Resident #57 and Resident #83) reviewed for abuse. Findings included. The facility policy titled; Abuse, Neglect, and Exploitation revised 08/30/23 indicated facility staff must immediately report allegations of abuse to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. A facility initial report dated 06/20/24 revealed the facility received an allegation on 06/13/24 at 8:00	F 607	Past noncompliance: no plan of correction required.	

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AM by Nurse #9 was reviewing clinical record that revealed on 06/12/24 at 3:30 PM Resident #57 slapped Resident #83 on the face. Administrator sent initial incident report to the Department of Health and Human Services (DHHS) fax 06/13/24 at 8:43 AM.,

An interview was conducted on 08/27/24 at 3:05 PM with Nurse #7. Nurse #7 stated on 06/12/24 at approximately 3:30 PM Resident #57 and Resident #83 were sitting in their wheelchairs together by resident room laughing and being friends, when suddenly, Resident #57, for no apparent reason, slapped Resident #83 on the face. Nurse #7 said she immediately separated the two residents, assessed Resident #83 for injuries, which revealed none. Resident #57 was placed on every 15-minute checks. Nurse #7 said she immediately informed Nurse #8 of the incident and started every 15-minute checks on Resident #57. She said she reported the 06/12/24 abuse immediately to her nursing supervisor, but did not call the Administrator. Nurse #7 said she thought her supervisor, Nurse #8, reported the incident to the Administrator. Nurse #7 said she had received abuse training when she was first hired on 06/05/24, and again from the 6/12/24 incident. She said the 06/13/24 abuse training included resident to resident incidents were to be considered abuse and should be reported immediately to the Administrator.

A written statement from Nurse #8 revealed: "On 06/12/24 the new employee [Nurse #7] asked her what she should do about a patient hitting another patient, I stated, write a note about the incident and make sure to document on the (every) 15-minute check list the occurrence. [Nurse #8]

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said she totally forgot about telling her to call the on-call supervisor or Director of Nursing [DON]".

Attempted to interview Nurse #8 by phone and she was unable to be reached.

An interview was conducted on 08/27/24 at 3:45 PM with the Administrator. The Administrator stated she was notified by Nurse #9 on 06/13/24 around 8:00 AM of the incident regarding Resident #57 and Resident #83. The Administrator stated both Nurse #7 and Nurse #8 should have immediately called the Administrator or DON right after the incident occurred. The Administrator stated staff had been trained numerous times to report any incidents of abuse immediately. She stated the incident on 06/12/24 should have been reported that day but stated that didn't happen. She stated a plan of correction regarding the abuse allegation and not reporting abuse was initiated on 06/13/24.

The corrective action for the noncompliance dated 06/13/24 was as follows:

1.) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 06/12/24 a severely impaired resident slapped another severely impaired resident's face who was sitting next to her. Facility staff (Nurse #7 and Nurse #8) failed to report the incident until 06/13/24.

On 06/13/24 counseling and education was done by the Director of Nursing with the two employees (Nurse #7 and Nurse #8) that failed to report timely.

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2.) Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On June 13, 2024, all staff were interviewed to ensure there were no additional cases of unreported abuse. There were no additional findings.

3.) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 06/13/24 the DON/Designee started abuse education with all staff. The training included in part; Resident to resident incidents are considered abuse and must be reported immediately, separate residents, report to supervisor, and call Administrator. Education was completed by 06/13/24. All staff would be required to sign training signature sheet prior to their next shift.

4.) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The DON/designee to ask 5-staff members a week who the abuse coordinator is and if they know what to do if they see abuse including resident to resident abuse allegations. Facility Administrator or designee will conduct a 10-week audit to ensure that staff know what to do for abuse and who the abuse coordinator is. Results will be reviewed at facility's QAPI (Quality Assurance Performance Improvement) meetings for the duration of the 10-week audits including monitoring to ensure staff reported abuse

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F 607	Continued From page 5 allegations within the required timeframe. Reviewed 10-week audits that were completed. An ad hoc QAPI meeting was completed on 06/13/24 with the interdisciplinary team. The Medical Director was notified by the Administrator. 5.) The facility alleged compliance with the corrective action plan on 06/14/24. The completion of the self-imposed corrective action plan was verified on-site through staff interviews and record review Validation of the corrective action plan was completed on 08/30/24. This included staff interviews and in-service training that was received to ensure understanding and knowledge of the training provided. Staff interviews revealed following in-service training they had a better understanding of the reporting requirement related to abuse allegations. The initial interviews were verified. There were no concerns identified. The last QAPI meeting was held August 2024 where audit results were discussed. The corrective action plan was validated to be completed as of 6/14/24.	F 607		
F 758 SS=D	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;	F 758		9/20/24

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F 758	Continued From page 6 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their 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.	F 758		

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F 758	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the Medical Director, and the Consultant Pharmacist, the facility failed to ensure an as needed (PRN) psychotropic medication Lorazepam prescribed for anxiety was limited to 14 days or document the continued use with a rationale and duration for 2 of 5 residents (Resident #45 and Resident #21) reviewed for medication administration. Findings included. 1.) Resident #45 was admitted to the facility on 6/11/2024 with diagnoses to include age-related cognitive decline and dementia, moderate, with anxiety. The physician orders for Resident #45 revealed an order written on 7/15/2024 for lorazepam (an antianxiety medication) 0.5 milligrams (mg) tablet every 8 hours as needed (PRN). One tablet orally every 8 hours PRN for dementia, moderate, with anxiety. There was no end date or rational documented for the lorazepam 0.5 mg every 8 hours PRN. The Pharmacy Consultant's recommendations dated 7/30/2024 for Resident #45 revealed the following recommendation: "PROMPT RESPONSE REQUESTED. Resident #45 has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date. Lorazepam 0.5 mg TAKE 1 TAB BY MOUTH EVERY 8 HOURS AS NEEDED FOR ANXIETY. Please discontinue PRN lorazepam, tapering as necessary. If the medication cannot be discontinued at this time, please document the	F 758	F758 1. Resident # 45 had a PRN Ativan order with no stop date. Stop date was corrected on 9/5/2024. Resident #21 had a PRN Ativan order with no stop date. Stop date was corrected on 8/30/2024. 2. DON and/or designee conducted a 100% audit to ensure all PRN psych meds had a proper stop date 9/5/2024. Any without a stop date will be reviewed and corrected. 3. Nursing staff will be educated on adding stop dates to PRN psych medications by the Director of Nursing or designee by 9/19/2024. 4. DON and/or designee will run a psychotropic medication report weekly for 12 weeks to ensure PRN medications have a proper stop date. The audits will be reported to the Quality Assurance Performance Improvement committee monthly for 3 months. AOC: 9/20/2024	

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indication for use, the intended duration of therapy, and the rationale for the extended time period."

The August 2024 medication administration record for Resident #45 revealed from 8/1/2024 through 8/28/2024 she received 16 doses of lorazepam, 0.5 mg tablet PRN.

An interview was completed with the Director of Nursing (DON) on 8/29/2024 at 11:53 AM. The DON stated new orders were reviewed every morning by administrative nursing staff. She further stated all medications were reviewed and stop dates were verified for PRN medications. The DON indicated she did not know how Resident #45's PRN lorazepam's stop date was missed. She stated that all psychotropic medications were supposed to have a stop date and could not be PRN for more than 14 days.

An interview was completed with the Medical Director on 8/29/2024 at 12:02 PM. The Medical Director stated it was the clinician's responsibility to make sure there was a stop date on all psychotropic medications. He further stated that when clinicians were in a nursing home, they must follow the nursing home rules.

A telephone interview was conducted with the Consultant Pharmacist on 8/29/2024 at 2:33 PM. The Consultant Pharmacist stated there was a problem at the facility with PRN psychotropic medications not having a 14 day stop date. He stated that he thought the facility had put something in place to prevent this from recurring. The Consultant Pharmacist stated he had even spoken to the Medical Director and that even if a resident was on Hospice, all PRN medications

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needed to have a stop date.
2.) Resident #21 was admitted to the facility on 05/05/21 with diagnoses including vascular dementia and anxiety.

A physician's order dated 04/27/24 for Resident #21 revealed Lorazepam 0.25 milligrams (mg). Give 0.25 mgs by mouth every 12 hours as needed for anxiety. This remained an active order.

Review of the Medication Administration Record (MAR) dated 04/27/24 through 08/28/24 revealed Lorazepam 0.25 milligrams was not administered to Resident #21.

The Minimum Data Set (MDS) quarterly assessment dated 06/11/24 revealed Resident #21 was severely cognitively impaired and received psychotropic medications.

Review of the Monthly Medication Review dated 07/30/24 conducted by the Consultant Pharmacist revealed to add a stop date to Resident #21's Lorazepam 0.25 mg as needed order.

During an interview on 08/29/24 at 1:53 PM the Medical Director stated he was aware that as needed psychotropic medications were to be limited in duration. He reported that the physicians were responsible to write orders for psychotropic medications to include a 14 day stop date or document a rationale for continued use. He indicated they had recently recognized the issue and would get it resolved.

During an interview on 08/29/24 at 2:07 PM the Director of Nursing (DON) along with the

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F 758	Continued From page 10 Regional Director of Clinical Services stated interdisciplinary team meetings were held daily, and all new orders were reviewed to verify that as needed psychotropic medication orders were limited to 14 days or had a rationale for continued use. The Regional Director of Clinical Services reported they had recently realized the issue regarding 14 day stop dates for psychotropic medications and were scheduled to meet with the Consultant Pharmacist to discuss psychotropic medications and durations. She indicated they would initiate a 100% audit of psychotropic medications to ensure a duration was on the order. She indicated education would be provided to ensure 14 day stop dates were added to the medication orders. During a phone interview on 08/29/24 at 6:35 PM the Consultant Pharmacist stated he was aware that a 14-day duration was not being added to as needed psychotropic medications. He reported he would be working with the facility administration and the Medical Director to get the issue resolved.	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 observations, record review and staff interviews the facility failed to maintain a medication rate greater than 5% when 4 medications were noted to be omitted. The result	F 759	F759 1. On 9/16/2024 the Provider was notified of Medication Errors that occurred for	9/20/24

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F 759	Continued From page 11 of the medication errors could have resulted in a negative effect for 1 of 3 residents (Resident #45) observed for medication administration. The medication error rate was 16%. Findings included: The Minimum Data Set admission assessment dated 06/18/24 revealed Resident #45 was cognitively aware. On 08/28/24 at 9:10 AM a medication administration pass was observed with Nurse #2 for Resident #45. Nurse #2 was observed preparing the following medications for administration: Amlodipine (medication to treat high blood pressure) 10 milligrams (mg) one tablet, Aripiprazole (medication to treat psychosis) 5 mg one tablet, Buspirone (medication to treat depression) 10 mg one tablet, Celebrex (medication to treat arthritis) 100 mg one tablet, Divalproex (medication to treat epilepsy) 250 mg one tablet, famotidine (medication to treat gastric reflux disease) 20 mg one tablet, hydrochlorothiazide (medication to treat high blood pressure) 12.5 mg one tablet, Lasix (a diuretic medication to remove fluid) 20 mg one tablet, Lisinopril (medication to treat high blood pressure) 20 mg one tablet, Myrbetriq (medication for overactive bladder) 25 mg one tablet, primidone (medication to treat epilepsy) 50 mg one tablet, Potassium (supplement medication) 10 milliequivalents one tablet, Memantine (medication to treat dementia) 10 mg one tablet, Propranolol (medication to treat high blood pressure) 10 mg one tablet, and Sertraline (medication to treat depression) 50 mg 3 tablets. After preparing the medications, Nurse #2	F 759	resident #45 on 8/28/2024. 2. A 100% Medication Administration audit will be conducted by DON or designee with licensed nurses by 9/19/2024. 3. Education will be conducted by DON and or designee on the Five Rights of medication administration and proper medication administration by 9/19/2024. 4. The Director of Nursing or designee will conduct 3 medication administration audits per week for 12 weeks then 1 medication administration audit for an additional 12 weeks to ensure ongoing compliance. Results will be reviewed by the Quality Assurance Performance Improvement Committee for 6 months. AOC Date: 9/20/2024	

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entered Resident #45's room and asked Resident #45 if she was having any pain and what the scale of pain was from 1 - 10. Resident #45 stated she wanted her Tramadol medication for a pain level of 6 out of 10 and also asked for her antianxiety medication.

On 08/28/24 at 9:15 AM, Nurse #2 was observed preparing the Tramadol (a medication to treat pain) 50 mg one tablet and Lorazepam (a medication to treat anxiety) 0.5 mg one tablet. Nurse #2 added the two additional medications to medication cup and entered Resident #45's room. Nurse #2 was observed administering all the medications she prepared for Resident #45. Resident #45 was noted to have swallowed all the medications that Nurse #2 handed her.

An interview with Nurse #2 on 08/28/24 at 9:20 AM revealed she had completed her medication administration pass for Resident #45 and had administered all of her medications that were ordered.

a. A review of the physician medication orders during reconciliation on 08/28/24 at 9:30 AM, it was noted Nurse #2 had omitted administering Resident #45 the physician ordered Budesonide suspension nebulizer (an inhaling medication that reduces inflammation and swelling in the lungs) 0.25 mg/2 milliliters 1 vial twice a day.

A follow up interview with Nurse #2 on 08/28/24 at 9:45 AM revealed she had administered the Budesonide nebulizer treatment earlier this morning because Resident #45 was feeling short of breath.

b. A review of the physician medication orders

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during reconciliation on 08/28/24 at 9:30 AM, it was noted Nurse #2 had omitted administering two medications to treat constipation: Sennosides-Docusate Sodium two tablets to be given twice daily, and MiraLAX 17 grams once daily.

A follow up interview was conducted with Nurse #2 on 08/28/24 at 9:45 AM. Nurse #2 revealed she held the Sennosides and MiraLAX because the resident was having loose stools a couple of weeks ago when she was on the rehab hall. Nurse #2 was asked if she asked Resident #45 if she was still having loose stools before she held the medications and she stated "No." Nurse #2 stated she should have asked Resident #45 if she was still having loose stools and if she wanted her medications and should not have assumed Resident #45 was going to say "No."

An interview was conducted with the DON on 08/29/24 at 3:00 PM. The DON stated Nurse #2 should have assessed Resident #45 to see if she was having loose stools before making the decision to hold the medication. The DON stated if Resident #45 had asked to hold her Sennosides and MiraLAX, it was the nurse's responsibility to notify the physician and obtain an order to hold the medication. The DON further added, Nurse #2 should not have held the medications for loose stools Resident #45 was having 2 weeks ago.

c. A review of the physician medication orders during reconciliation on 08/28/24 at 9:30 AM, it was noted Nurse #2 omitted administering Aspirin (supplement) 81 mg one tablet.

A follow up interview with Nurse #2 on 08/28/24 at 9:50 AM was conducted. Nurse #2 stated she

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administered the Aspirin to Resident #45. At this time, the medications that were previously dispensed were reviewed with Nurse #2 revealing that Aspirin 81 mg was not noted on the list of medications already administered as observed during her medication pass. Nurse #2 stated "I guess I must have missed it." Nurse #2 removed the Aspirin from the drawer to prepare to administer to Resident #45. As Nurse #2 entered Resident #45's room to administer the Aspirin, she asked Resident #45 if she would wanted her Sennosides and or MiraLAX. Resident #45 refused both medications at this time as she was having loose stools. Nurse #2 administered Resident #45 her ordered Aspirin. At this time, Resident #45 was asked by this writer how she was feeling after her breathing treatment this morning. Resident #45 reported she had not received nebulizer treatments in weeks. Resident #45 was noted to have no shortness of breath or difficulty breathing at this time.

A follow up interview with Nurse #2 on 08/28/24 at 9:50 AM was conducted. Nurse #2 stated she never said that Resident #45 received the Budesonide. Nurse #2 was reminded that she indicated the resident was feeling short of breath and she administered the nebulizer earlier this morning. Nurse #2 stated she misspoke and stated she did not administer the nebulizer earlier this morning. Nurse #2 stated she would notify the physician regarding Resident #45's refusal of the Sennosides and MiraLAX due to loose stools and to change the treatments to as needed for the Sennosides, MiraLAX and Budesonide.

An interview was conducted with the DON on 08/29/24 at 3:00 PM. The DON stated her expectation of Nurse #2 was

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F 759	Continued From page 15 administering all medications as physician ordered. The DON stated she would have expected Nurse #2 to administer the Budesonide as ordered, and if Resident #45 refused the medication, she would have expected Nurse #2 to notify the physician that resident was refusing which would have warranted a reevaluation of Resident #45 to determine if the medication was still required. An interview was conducted with the Regional Clinical Director (RCD) on 08/29/24 at 3:00 PM The RCD stated that further education was going to be provided to this nurse regarding the five rights of medication administration.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, the Medical Director, and the Consultant Pharmacist interviews the facility failed to a.) implement an order for Metoprolol 12.5 milligrams twice a day (a beta blocker indicated for the treatment of hypertension and heart failure) that was prescribed for atrial fibrillation (irregular heart rhythm) and b.) implement an order for Magnesium Oxide 400 milligrams prescribed as a supplement for low magnesium levels. This occurred for 1 of 5 residents (Resident #21) reviewed for medication administration. Findings included.	F 760	F760 1. Resident #21's Metoprolol and Magnesium Oxide was reviewed by the facility MD. A Magnesium level was drawn on 8/30/2024. Resident's 25 mg Metoprolol was started on 8/29/2024. Resident with no negative outcome from med error. 2. 100% audit will be conducted by DON and/or designee to ensure that the orders from Point Click Care matched the orders in Matrix for active residents as of 8/29/2024. Any orders of concern will be	9/20/24

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F 760	Continued From page 16 1. Resident #21 was admitted to the facility on 05/05/21 with diagnoses including atrial fibrillation, long term use of anticoagulants, congestive heart failure, and hypomagnesemia. a.) A physician's order dated 05/04/24 for Resident #21 revealed Metoprolol 12.5 milligrams twice a day. Hold for systolic blood pressure less than 110 mm/hg (millimeters of mercury) or heart rate less than 55 beats per minute. A review of the Medication Administration Record (MAR) from 05/04/24 through 08/28/24 revealed no documentation that Metoprolol 12.5 milligrams twice a day was administered to Resident #21. A review of the progress notes from 05/04/24 through 08/28/24 revealed no documentation regarding the administration of Metoprolol 12.5 milligrams twice a day to Resident #21. A review of Resident #21's medical record from 05/04/24 through 08/28/24 revealed his heart rate ranged from 60 - 90 beats per minute which was within normal limits. His systolic blood pressure ranged 110-130's mm/hg and diastolic blood pressure ranged from 70-80's which were within normal limits. b.) A physician's order dated 05/04/24 for Resident #21 revealed Magnesium Oxide 400 milligram tablets give 400 milligrams by mouth two times a day for low magnesium level. A review of the Medication Administration Record (MAR) from 05/04/24 through 08/28/24 revealed no documentation that Magnesium Oxide 400 milligrams twice a day was administered to Resident #21.	F 760	addressed with the facility physicians for clarification by 9/19/2024. 3. Nurses and facility providers will be educated by the Director of Nursing or designee by 9/19/2024 on entering medication orders in Matrix. 4. The Director of Nursing will review the Order Report 5x week for 12 weeks to ensure all medication orders are entered correctly and have an appropriate schedule. All issues identified will be corrected immediately and reported to the provider. The audits will be reviewed by the Quality Assurance Performance Improvement Committee for 3 months. Corrective action date: 9/20/2024	

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A review of the progress notes from 05/04/24 through 08/28/24 revealed no documentation regarding the administration of Magnesium Oxide 400 milligrams twice a day to Resident #21.

Record review revealed the most recent magnesium level for Resident #21 dated 05/06/24 was 1.8 milligrams per deciliter. Normal magnesium levels range between 1.7 - 2.8 milligrams per deciliter (mg/dl).

The Minimum Data Set (MDS) quarterly assessment dated 06/11/24 revealed Resident #21 was severely cognitively impaired and required assistance with activities of daily living. He received anticoagulant medications.

A physician's note dated 07/16/24 revealed Resident #21 was evaluated with no new or worsening concerns. He had no respiratory concerns, his heart rate was regular with normal sinus rhythm. The plan of care in regard to atrial fibrillation was to continue Eliquis (anticoagulant) and the beta blocker. Resident #21's heart rate was controlled, blood pressure was well-controlled. With regard to heart failure, he remained euvolemic (the state of normal body fluid volume), continue diuretic and Metoprolol. Magnesium levels were within normal limits, and to continue magnesium supplement.

During an interview on 08/29/24 at 10:00 AM the Regional Director of Clinical Services stated the facility transitioned to a new electronic medical record system in May 2024. She reported that the actual system merge date occurred on 04/27/24 however they didn't go live with the new system until 05/07/24. She stated between 04/27/24

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through 05/07/24 the nursing staff were instructed to enter any new medication orders into both the old and new electronic medical record systems since the system merged and all the data transferred on 04/27/24. She stated most likely since the orders were actually entered into the old electronic medical record on 05/04/24 the nurse didn't enter the Metoprolol or the Magnesium Oxide order into the new medical record system as instructed. She reported that staff were trained on the new electronic medical record system and were instructed to enter orders into both systems until 05/07/24.

During a phone interview on 08/29/24 at 1:43 PM Nurse #13 stated she did not recall entering the orders for Metoprolol or Magnesium Oxide for Resident #21 but stated during that time they transitioned from the old electronic medical record system to the new system. She stated she worked per diem (as needed) and she didn't know how to do anything in the new medical record system at that time. She stated she did attend training but still didn't understand the new system. She stated she was not aware that she had to enter medication orders in both the old and new system during that time. She indicated it was done in error.

During an interview on 08/29/24 at 2:00 PM the Medical Director stated he wrote the order for a low dose of Metoprolol for Resident #21 on 05/04/24 because he had not been on Metoprolol since 2021. He stated he wanted to start a trial dose although it was a very low dose only to add additional protection. He reported he was not aware the medication had not been administered but stated Resident #21's heart rate was well controlled and remained at 70-80 beats per

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minute and indicated his blood pressure was well controlled. He stated Resident #21 had no significant outcome from not receiving the low dose of Metoprolol and the potential outcome would be his heart rate or blood pressure would increase but they would have caught that from routine monitoring of his vital signs. He reported the Magnesium Oxide was ordered as a supplement, but his magnesium level was within normal limits. He stated not receiving the medications has had no effect on Resident #21 due to having no change in condition and he remained at his baseline.

During an interview on 08/29/24 at 3:14 PM Nurse #6 stated she was routinely assigned to provide care to Resident #21. He was alert and oriented to person only. She stated he was compliant most of the time with his medications and his vital signs were stable, and there had been no change in his condition.

During an observation on 08/29/24 at 3:30 PM Resident #21 was observed sitting up in his wheelchair at the nurses station. He was oriented to person only. He was in no distress.

During an interview on 08/29/24 at 4:00 PM the Administrator stated she was made aware of the medication error today and indicated the error occurred during the transition to the new electronic medical record system. She stated a full audit of all medications had already been initiated. She indicated the Director of Nursing, and the Regional Director of Clinical Services were completing a 100% audit of all medications and education to the nursing staff would be provided.

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F 760	Continued From page 20 During a phone interview on 08/29/24 at 6:35 PM the Consultant Pharmacist stated he didn't think Resident #21 needed to be on a beta blocker because he was on an anticoagulant twice a day and his heart rate and blood pressure were well controlled. He reported Resident #21 had not been on Metoprolol prior to the order written on 05/04/24 and due to polypharmacy and being on an anticoagulant he didn't think Metoprolol was needed. He stated if the Medical Director decided to initiate low dose Metoprolol at this point, he would most likely recommend to discontinue the Metoprolol on his next monthly medication review. He stated there was typically no benefit in supplemental magnesium and there would be no outcome from not receiving the magnesium supplement.	F 760		
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	F 812		9/20/24

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F 812	Continued From page 21 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer and failed to ensure refrigerated food items stored for use in the walk-in refrigerator for residents' meals were dated. These practices had the potential to affect 90 of 91 residents' food quality and kitchen sanitation safety. Findings included: a) The initial tour of the kitchen conducted on 08/24/24 at 11:35 AM the Dietary Cook said the staff used the solution in the two red buckets to wipe down the main food preparation table area after food preparation and prior to manning the tray line. The Cook said their stainless-steel food preparation tables were wiped down before breakfast and again just before lunch tray line set-up using the sanitizing solution kept in the two red sanitizing buckets kept under the kitchen's food preparation tables. At 12:45 AM on 08/24/24 strips were used to check the sanitizing solution in the kitchen's two red sanitizing buckets. The solution in the bucket registered 0-parts per million (PPM) of quaternary sanitizer. Cook reported she or her staff did not check the strength of the sanitizing solution in the bucket when it was filled that morning, prior to wiping down all food preparation table services. She said her dietary kitchen aides should have test stripped the buckets solution's strength throughout the day, to keep them between 200 -	F 812	F 812- 1. A. On 8/24/2024 the sanitation buckets where filled and tested properly by the cook, reading 200-300 PPM. B. ON 8/26/2024 an observation of the walk in refrigerator showed three half gallon clear plastic containers of tuna salad, ham salad and fortified chocolate pudding without opened dates or end dates. These items were discarded by the CDM. 2. All residents could be affected by this deficient practice. Items were corrected immediately and no concerns noted by the nursing department of health concerns. 3.On 8/26/2024 dietary staff were educated on sanitation and proper food storage and labeling by the CDM. 4. Audits will be conducted by the CDM or designee for 12 weeks Monday through Friday on ensuring that the sanitation buckets reach required levels for sanitation and items are stored with proper dates. Results will be brought to the facility QAPI meeting. AOC 9/20/2024	

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300 PPM. The Cook then demonstrated how to properly fill the red sanitizing bucket, by first filling the bucket with clean tap water, then she added the proper amount of sanitizing solution to the buckets, and finally she tested the red bucket's solution with a test strip that read 200 - 300 PPM, which the Cook said was acceptable for disinfecting food preparation services.

The Dietary Manager (DM) was interviewed on 08/26/24 at 11:35 AM said she preferred the quaternary solution in the red sanitizer bucket to register 200 - 300 PPM when checked with the appropriate strips. She reported when the strength was less than this there was a chance that the surfaces being wiped down were not properly disinfected. She commented the strength of the solution in the bucket should be checked when the bucket was made up and should not have registered 0-PPM. The DM then tested the two red buckets solution with a test strip that read 200 - 300 PPM, which the DM said was acceptable for disinfecting food preparation services.

b) A follow-up interview and kitchen observation were conducted on 08/26/24 at 11:40 AM with the DM. An observation of the kitchen's walk-in refrigerator, with the DM revealed; three half-gallon clear plastic containers of tuna salad, ham salad, and fortified chocolate pudding, were without opened dates or end dates. The DM was unable to explain why food stored in the kitchen's walk-in refrigerator was not dated properly.

During an interview with the DM on 08/26/24 at 12:00 PM she said she monitored the items in the refrigerators and freezers weekly when conducting inventory. She stated the containers

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F 812	Continued From page 23 of tuna salad, ham salad, and fortified chocolate putting should have been dated properly, with both an open date and end date. During an interview with the Administrator on 08/29/24 at 1:30 PM, she reported it was her expectation the facility's kitchen staff follow all regulatory guidelines for food and kitchen sanitation safety.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		9/20/24

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F 842	Continued From page 24 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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F 842	Continued From page 25 Based on observations, record review and staff interviews the facility failed to accurately document the administration of medications in the electronic medical administration record (eMAR) for 1 of 3 residents (Resident #45) observed during a medication pass observation. Findings included: The Minimum Data Set admission assessment dated 06/18/24 revealed Resident #45 was cognitively aware. On 08/28/24 at 9:10 AM, a medication administration pass was observed with Nurse #2 for Resident #45. Nurse #2 indicated at 9:20 AM she had completed her medication pass and had administered all the medications as ordered. a. A review of the physician medication orders during reconciliation on 08/28/24 at 9:30 AM, it was noted Nurse #2 had omitted giving Resident #45 the physician ordered Budesonide Suspension nebulizer (an inhaling medication that reduces inflammation and swelling in the lungs) 0.25 milligram (mg)/2 milliliters (ml) 1 vial to be administered twice a day. A review of the eMAR for August 28, 2024, revealed Nurse #2 had signed off that she had administered the Budesonide Suspension nebulizer 0.25 mg/2 milliliters as evidenced by a check mark and Nurse #2's initials. An interview with Nurse #2 on 08/28/24 at 9:45 AM revealed she did not administer the Budesonide nebulizer treatment and she should not have signed it off as given. Nurse #2 stated that it was inaccurate documentation.	F 842	F842 Medical record accuracy 1. The Medication Administration Record was corrected by Nurse #2 and the Regional Director of Clinical Services. Nurse #2 no longer works in the facility. 2. A Medication Administration audit will be conducted by DON or designee with licensed nurses by 9/19/2024. 3. The DON or designee will educate all nurses on ensuring the Medication Administration Record is accurate following each med pass by 9/19/2024. 4. Medication Pass audit will be conducted with licensed nurses. The audit will include 3 nurses for 12 weeks and will include ensuring the Medication Administration Record is accurate. Any inaccuracy will be corrected by the Director of Nursing or designee. The audits will be reviewed by the Quality Assurance Improvement Committee monthly for 3 months. AOC 9/20/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 26	F 842		

b. A review of the physician medication orders during reconciliation on 08/28/24 at 9:30 AM, it was noted Nurse #2 had omitted administering two medications that were ordered to treat constipation: Sennosides-Docusate Sodium two tablets twice daily, and MiraLAX 17 grams once daily.

A review of the eMAR for August 28, 2024, revealed Nurse #2 had signed off that she had administered the Sennosides two tablets and MiraLAX 17 grams as evidenced by a check mark and Nurse #2's initials.

An interview was conducted with Nurse #2 on 08/28/24 at 9:45 AM. Nurse #2 revealed she held the Sennosides and MiraLAX because the resident was having loose stools a couple of weeks ago when she was on the rehabilitation hall. Nurse #2 stated she signed it off as given because it was easier than documenting the medication was refused because she would have to write a progress note. Nurse #2 stated she should not have signed the medications off as given because it indicated the resident was still requiring the medication for constipation when in fact, she was having loose stools and did not need the medication. At this time, on 08/28/24 at 9:50 AM, Nurse #2 entered Resident #45's room and asked her if she wanted her Sennosides and MiraLAX medications. Resident #45 refused the medications.

c. A review of the physician medication orders during reconciliation on 08/28/24 at 9:30 AM, it was noted Nurse #2 omitted administering Aspirin (supplement) 81 mg one tablet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 27	F 842		

A review of the MAR for 08/28/24, revealed Nurse #2 had signed off that she had administered the Aspirin 81 mg as evidenced by a check mark and Nurse #2's initials.

An interview with Nurse #2 on 08/28/24 at 9:50 AM was conducted. Nurse #2 stated she had omitted administering the Aspirin during the medication pass and should not have signed it off as given until the medication was actually given.

An interview was conducted with the Director of Nursing (DON) on 08/29/24 at 3:00 PM. The DON stated her expectation of Nurse #2 was to accurately document the administration of medications to ensure she was administering all medications as physician ordered. The DON stated it was important to document medication administration accurately to determine how the resident was responding to ordered medications. The DON stated Nurse #2 had contacted the physician today to get an order to change the Sennosides and MiraLAX to as needed instead of scheduled and let the physician know Resident #45 was having loose stools.

An interview was conducted with the Regional Clinical Director on 08/29/24 at 3:00 PM who stated that further education was going to be provided to this nurse regarding the five rights of medication administration.