STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075397	A. Building B. Wing	04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Haven Center for Nursing & Rehabilitation LLC	181 Clifton Street New Haven, CT 06513

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35682 Based on review of the clinical record, facility documentation, facility policy and interview for 2 of residents (Resident #1 and #2) reviewed for dignity, the facility failed to ensure residents were treated in a dignified manner. The findings include: 1. Resident #1's diagnoses included schizophrenia, anxiety, hypertension and gastroesophageal reflux disease (GERD). The quarterly MDS dated [DATE] identified Resident #1 had intact cognition, required limited assistance with activities of daily living and supervision with mobility. Interview with the Independent Nurse Consultant (INC) on 3/23/22 at 3:20 PM identified while in the facility on 3/15/22 she observed Resident #1, who was crying and visibly upset, approach APRN #1 requesting medication because he/she was having chest pain. The INC identified she asked the resident if he/she was alright and APRN #1 stated he/she's okay, it's all in his/her head. The ICN indicated although APRN #1 directed his comment to her (ICN), it was said in the presence of Resident #1. The INC identified she escorted Resident #1 to his/her room and asked LPN #1 to check the residents blood pressure, indicating the resident was not feeling well and complaining of chest pain. The ICN identified Resident #1's blood pressure was checked, resident was assessed, provided support and reassurance and was given medication for indigestion. After several minutes, the ICN identified Resident #1 indicated he/she felt better with no further complaints of chest pain. The ICN identified she reported the incident to the DNS who contacted MD #1 and arranged a meeting to discuss concerns about APRN #1. Interview with LPN #1 on 3/23/22 at 3:30 PM identified she did recall the ICN recently approaching her and requesting to check Resident #1's blood pressure. LPN #1 identified the resident's blood pressure was checked and was within normal limits. LPN #1 identified the resident does become anxious at times requiring support and reassurance and indicated the resident became less anxious and reported his/her symptoms may have been due to indigestion. Resident #1 was given antacid medication with good effect and voiced no further complaints or discomfort. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 3/23/22 at 3:45 PM identified he was informed sometime last week by the ICN that Resident #1 had complained of not feeling well to APRN #1 and that APRN #1 made an undignified comment to the ICN in front of Resident #1. The DNS identified he contacted MD #1 and a meeting was held with himself, the ICN, MD #1 and APRN #1 to address the issue. The DNS indicated that although he was informed of and addressed the ICN's concerns related to APRN #1's undignified comments regarding Resident #1, he had no documented information regarding the incident. The DNS identified that all residents should be treated with respect and dignity. Interview with APRN #1 on 3/24/22 at 10:10 AM identified Resident #1, who was well known to him, had a tendency to become fixated on things and responded better to a firm, direct approach. Although APRN #1 indicated he may have made an inappropriate comment to the ICN, he did not intentionally say it to the resident and did not intend for resident to hear it. APRN #1 identified he did go to see resident and ordered an antacid medication and always follows up on resident concerns. Review of the Resident's Rights policy identified residents have the right to be treated with consideration, respect and full recognition of your dignity and individuality. 2. Resident #2 was admitted to the facility on [DATE] with diagnoses that included dementia without behavioral disturbance, schizoaffective disorder, anxiety disorder, psychosis, and depressive disorder. The quarterly MDS dated [DATE] identified Resident #2 had moderately impaired cognition and required limited assistance with personal hygiene. Interview with the Independent Nurse Consultant (RN #1) on 3/23/22 at 3:23 PM identified while in the facility on 3/10/22 between 12:00 PM and 1:00 PM she observed that NA #1 started rolling her eyes when she saw Resident #2 in the hallway by the patio exit door. RN #1 identified she explained to NA #1 that Resident #2 would like to go out to the patio for his/her smoking break and indicated NA #1 put her hand out (in a stop gesture) to the resident, and said I can't even deal with him/her (meaning Resident #2), in front of Resident #2. RN #1 indicated she educated NA #1 that she cannot talk in that manner in front of Resident #2 or any residents and indicated NA #1 stated Resident #2 is too much for her and that the resident kept asking her questions when he/she was out during smoking break. NA #1 stated that there are too many residents out there during smoking break for one nurse aide to do smoking alone. RN #1 indicated she spoke to the social worker who stated that NA #1 is always like that and RN #1 identified she reported the incident to the Acting DNS and the Administrator. Interview with the Social Worker on 3/23/22 at 3:27 PM identified she was aware of the alleged allegation of verbal mistreatment and indicated on 3/10/22 when she and RN #1 walked off the elevator, Resident #2 was approaching the patio and NA #1 was standing in the door way and said to Resident #2 (you need to bring a nurse's aide down when you come to smoke and I'm not letting you smoke). The Social Worker indicated RN #1 addressed the issue with NA #1 at that time. The Social Worker indicated in the past when NA #1 had an issue on the patio during smoking breaks, she would come and report the issues. The Social Worker indicated she did not report the incident to the Acting DNS or the Administrator. Interview with the Acting DNS on 3/23/22 at 3:35 PM identified he was aware of the allegation of verbal mistreatment when RN #1 reported the incident to him, and indicated the allegation had not been reported to the state agency. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 4/4/22 at 10:00 AM identified she does not remember the day the incident happened. NA #1 indicated she does not remember being unprofessional and using her hand when she spoke to Resident #2. NA #1 indicated she told Resident #2 that he/she needed to go and get a nurse aide if he/she wanted to smoke. NA #1 indicated the first time she heard about the incident is when the facility asked her to write a statement on 3/23/22. NA #1 indicated she did not report the incident to the Acting DNS. NA #1 indicated the Social Worker was present during this incident. Review of the resident rights policy identified the facility is to provide care and services in accordance with the Resident [NAME] of Rights as outlined by the Federal Nursing Home Reform Law. The Resident [NAME] of Rights is outlines as follows: You have the right to be treated with consideration, respect and full recognition of your dignity and individuality. You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. Review of the resident abuse, mistreatment, neglect, exploitation, misappropriation of resident property, and retaliation. To ensure that all staff know their responsibility in identifying and reporting any type of abuse, mistreatment, neglect, exploitation, misappropriation of property, and retaliation as per state and federal guidelines. Verbal abuse: defined as the intentional use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age: ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see their family again. Mistreatment: the inappropriate treatment or exploitation of a resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policies and interviews for 4 residents (Residents #3, 4, 5 and 6) reviewed for medication administration, the facility failed to notify the physician and/or resident representative when there were medication errors. Additionally, for 1 of 2 residents (Resident #8) reviewed for diabetic management, the facility failed to ensure the physician and the resident representative were notified in a when the resident's blood sugar was elevated. Further, for 1 of 2 residents, (Resident #9) reviewed for wounds, the facility failed to notify the physician and resident representative when the resident developed unstageable pressure ulcers. The findings include: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, paranoid schizophrenia, and depression. The physician's order dated 10/11/21 directed to administer Lorazepam (antianxiety medication) 2mg twice daily at 9:00 AM and 9:00 PM. The quarterly MDS dated [DATE] identified Resident #3 had intact cognition, was independent with bed mobility, required assistance with transfers and personal hygiene, and walked independently. The corresponding care plan identified Resident #3 had a potential for symptoms of depression related to the diagnosis of depression and anxiety. Interventions included to administer medications as ordered and observe for signs and symptoms of anxiety. Review of the Lorazepam controlled drug/receipt/record disposition form identified the last available dose of Lorazepam was administered on 3/12/22 at 9:00 PM. Review of the March 2022 MAR identified Resident #3 refused the scheduled dose of Lorazepam 2mg on 3/13/22 at 9:00 AM. Documentation indicated the resident is asleep and does not want to be woken up. The March 2022 MAR identified that LPN #5 administered Lorazepam 2mg on 3/13/22 at 9:00 PM. The March 2022 MAR identified that LPN #4 administered Lorazepam 2mg on 3/14/22 at 9:00 AM. The March 2022 MAR identified that LPN #8 administered Lorazepam 2mg on 3/14/22 at 9:00 PM. Facility documentation identified Resident #3 ran out of the Lorazepam 2mg on 3/12/22 at 9:00 PM and the pharmacy delivery sheet identified Resident #3 ' s Lorazepam 2mg was delivered to the facility on [DATE] at 12:50 AM, 2 days later. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility documentation identified that although the March 2022 MAR identified that Resident #3 received Lorazepam 2mg on 3/13/22 at 9:00 PM and 3/14/22 at 9:00 PM, the residents supply of Lorazepam was not available between 3/12/22 at 9:00 PM - 3/15/22 at 12:50 AM. Additionally, the cubex emergency medication kit documentation failed to reflect that the Lorazepam 2mg had been withdrawn for administration on 3/13/22 at 9:00 PM or on 3/14/22 at 9:00 PM. Further, the cubex emergency medication kit documentation identified the 3/14/22 9:00 AM dose of Lorazepam 2mg was withdrawn on 3/14/22 at 2:00 PM, 5 hours late. Interview with the DNS on 3/22/22 at 4:07 PM identified a medication error report was not completed when Resident #3 missed 2 doses of Lorazepam because he was not aware that Resident #3 had missed 2 doses of Lorazepam on 3/13/22 at 9:00 PM and 3/14/22 at 9:00 PM. The DNS also identified the physician, nor the responsible party had been made aware of the medication error. The DNS identified that the Lorazepam 2mg dose for 3/14/22 at 9:00 AM was administer late at 2:30 PM. Interview with APRN #1 on 3/23/22 at 10:00 AM identified he was not aware that Resident #3 missed 2 doses of Lorazepam on 3/13/22 at 9:00 PM and on 3/14/22 at 9:00 PM. Interview with the Medical Director on 3/23/22 at 10:30 AM identified that he was not aware that Resident #3 missed 2 doses of Lorazepam. Interview with the DNS on 3/24/22 at 11:50 AM identified licensed nurses should not document that a medication has been administered on the MAR when it has not. Additionally, the DNS identified that if a medication is not available, the nurse is responsible to notify the supervisor and the physician/APRN as an alternative medication may be available or if the physician deems it safe to hold the medication, and the pharmacy should be called to get the medication ordered. The DNS identified that if a nurse signs/initials on the MAR that a medication has been administered, but the medication was not administered, that it is a medication error and false documentation. Although attempted, an interview with LPN #5 and 8 was not obtained. Review of the medication administration policy directed if a medication is not available, it is the nurse ' s responsibility to try to procure the medication and any missed doses must be reported to the responsible party, Medical Director/APRN, shift supervisor and must be documented in Matrix along with all attempts to obtain the medication. Review of the medication reorder policy directed when a medication has 8 days left in supply the charge nurse is to request a refill utilizing the resupply button located in the electronic medication administration record. If a medication is down to 3 days left in supply, the charge nurse will contact the pharmacy to get an expected delivery date, and if the medication does not arrive and a dose is due, the charge nurse will contact the pharmacy and document the reason for delay in delivery, contact MD/APRN for alternative orders and write a progress note to document follow-up. The facility failed to notify the physician and the responsible representative when 2 doses of Lorazepam were omitted in error. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 11/1/21 directed to administer Lorazepam (antianxiety medication) 0.5mg twice daily at 9:00 AM and 9:00 PM. The quarterly MDS dated [DATE] identified Resident #4 has moderately impaired cognition. The corresponding care plan identified Resident #4 receives antianxiety medication related to anxiety disorder. Interventions included to administer medications as order, observe resident for signs or symptoms of anxiety or restlessness, psychiatry consultation and update the physician with concerns or changes. Review of the Lorazepam controlled drug/receipt/record disposition form identified the last available dose of Lorazepam was administered on 3/13/22 at 9:00 PM. The March 2022 MAR identified that LPN #4 administered Lorazepam 0.5mg on 3/14/22 at 9:00 AM. Facility documentation identified Resident #4 ran out of the Lorazepam 0.5mg on 3/13/22 at 9:00 PM and the pharmacy delivery sheet identified Resident #4 ' s Lorazepam 0.5mg was delivered to the facility on [DATE] at 12:50 AM, 1 day later. Review of facility documentation identified that although the March 2022 MAR identified that Resident #4 received Lorazepam 0.5mg on 3/14/22 at 9:00 AM, the residents supply of Lorazepam was not available between 3/13/22 at 9:00 PM - 3/15/22 at 12:50 AM. Additionally, the cubex emergency medication kit documentation failed to reflect that the Lorazepam 0.5mg had been withdrawn for administration on 3/14/22 at 9:00 AM. Interview with the DNS on 3/22/22 at 4:07 PM identified a medication error report was not completed when Resident #4 missed 1 dose of Lorazepam because he was not aware that the dose was missed on 3/14/22 at 9:00 AM. The DNS also identified the physician, nor the responsible party had been made aware of the medication error. Interview with APRN #1 on 3/23/22 at 10:00 AM identified he was not aware of the medication error. Interview with the Medical Director on 3/23/22 at 10:30 AM identified that he was not aware that Resident #4 did not receive the Lorazepam 0.5mg on 3/14/22 at 9:00 AM. Interview with the DNS on 3/24/22 at 11:50 AM identified licensed nurses should not document that a medication has been administered on the MAR when it has not. Additionally, the DNS identified that if a medication is not available, the nurse is responsible to notify the supervisor and the physician/APRN as an alternative medication may be available or if the physician deems it safe to hold the medication, and the pharmacy should be called to get the medication ordered. The DNS identified that if a nurse signs/initials on the MAR that a medication has been administered, but the medication was not administered, that it is a medication error and false documentation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #4 on 3/25/22 at 2:30 PM identified that she believes she did call the pharmacy to get the Lorazepam and other narcotics needed. LPN #4 indicated there were some medications given to her on 3/14/22 for other residents, and she indicated she thought she had Resident #4 ' s or might have missed it and signed the MAR by mistake. LPN #4 could not recall the details as she had called the pharmacy that day for other narcotics she needed. Review of the medication administration policy directed if a medication is not available, it is the nurse ' s responsibility to try to procure the medication and any missed doses must be reported to the responsible party, Medical Director/APRN, shift supervisor and must be documented in Matrix along with all attempts to obtain the medication. Review of the medication reorder policy directed when a medication has 8 days left in supply the charge nurse is to request a refill utilizing the resupply button located in the electronic medication administration record. If a medication is down to 3 days left in supply, the charge nurse will contact the pharmacy to get an expected delivery date, and if the medication does not arrive and a dose is due, the charge nurse will contact the pharmacy and document the reason for delay in delivery, contact MD/APRN for alternative orders and write a progress note to document follow-up. The facility failed to notify the physician when 1 dose of Lorazepam was omitted in error. 3. Resident #5 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome, poly neuropathy, and pain in the right wrist. The quarterly MDS dated [DATE] identified Resident #5 had intact cognition and experiences pain frequently. The corresponding care plan identified Resident #5 had the potential for alteration in comfort related to chronic pain syndrome, neuropathy and reports of right wrist pain. Interventions included to administer analgesics as ordered and evaluate the effectiveness of pain interventions. The physician's order dated 2/24/22 directed to administer MS Contin (pain medication) 15mg every 8 hours (as part of a 45mg total dose), and MS Continue 30 mg every 8 hours, (as part of the 45 mg total dose). The March 2022 MAR identified that MS Contin 30mg was documented as not available on 3/13/22 at 6:00 AM, 2:00 PM and 10:00 PM, and again on 3/14/22 at 6:00 AM. (for a total of 4 missed doses). The March 2022 MAR identified that MS Contin 15mg was documented as not available on 3/13/22 at 6:00 AM, 2:00 PM and 10:00 PM, and again on 3/14/22 at 6:00 AM. (for a total of 4 missed doses). Review of the nurse ' s note for 3/13/22 failed to reflect that staff had monitored or assessed Resident #5 ' s pain, or that the physician had been notified of the 3 missing doses of MS Contin omissions. Subsequent to APRN notification, on 3/14/22 at 8:09 AM, Resident #5 was assessed for pain and Oxycodone 20mg was ordered to be administered twice on 3/14/22 until the MS Contin was delivered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility documentation identified the MS Contin 30mg was delivered to the facility on [DATE] at 12:16 PM. The clinical record identified that Oxycodone 20mg was administered on 3/14/22 at 2:30 PM and 9:00 PM. The March 2022 MAR identified that MS Contin 30 mg was administered on 3/14/22 at 10:00 PM. (The resident had just received Oxycodone 20mg at 9:00 PM). The March 2022 MAR identified that MS Contin 15mg (part of the 45mg dose) was documented as either on order or not available on 3/15/22 at 6:00 AM, 2:00 PM and 10:00 PM and on 3/16/22 at 6:00 AM, 2:00 PM and 10:00 PM for a total of 7 missed doses. Facility documentation identified MS Contin 15mg was delivered on 3/17/22. Interview and review of the clinical record with the DNS on 3/21/22 at 2:30 PM identified that he became aware on 3/14/22 that Resident #5 had not received MS Contin as ordered on 3/13/22 for 3 doses and 3/14/22 1 dose. The DNS identified that he notified APRN #1 on 3/14/22, however, prior to that date the physician had not been notified of the medication omissions. The DNS identified that medication error reports had been completed for the medication omissions that occurred on 3/13/22 (3 doses) and 3/14/22 (1 dose). The DNS further indicated that he was not aware that as of 3/14/22 at 10:00 PM through 3/16/22 at 10:00 PM, Resident #5 was receiving MS Contin 30mg and not the full dose of MS Contin 45mg (as the MS Contin 15 mg had not yet been delivered), and that the physician had not been made aware. Interview and review of the clinical record with Pharmacy Representative #1 on 3/22/22 at 3:00 PM identified that Resident #5 ' s MS Contin 30mg and MS Contin 15mg were refilled on 2/23/22. Pharmacy Representative #1 identified on 3/2/22 the pharmacy had received a refill request for both the MS Contin 15mg and 30mg. The MS Contin 30mg was rejected because the pharmacy system stated it was a duplicate refill and the pharmacy technician deleted the order for the MS Contin 30mg, and the facility received only the MS Contin 15mg, and were administering 3 (15mg) tablets of the MS Contin 15mg to total the ordered dose of 45mg. Pharmacy Representative #1 indicated that Resident #5 ' s MS Contin 30mg refill request was received at the pharmacy on 3/14/22 at 8:05 AM and delivered and signed by the facility on 3/14/22 at 12:16 PM. Pharmacy Representative #1 further indicated that on 3/2/22 the pharmacy technician should have called the nursing home for clarification of the MS Contin 30mg order, and not just delete the order from the pharmacy system. Review of the inventory on hand available in the cubex emergency medication kit identified MS Contin is not stocked in the cubex. Interview with APRN #1 on 3/23/22 at 10:00 AM identified that he was notified on 3/14/22 that Resident #5 did not receive his/her MS Contin 45mg (3 doses) on 3/13/22 and (1 dose) on 3/14/22. APRN #1 indicated he ordered Oxycodone 20mg to be given twice on 3/14/22 until the MS Contin was delivered. ARPN #1 assessed Resident #5 on 3/14/22 and there were no complaints of pain. ARPN #1 identified he was not aware that Resident #5 received only MS Contin 30mg (instead of 45mg) from 3/14/22 at 10:00 PM through 3/16/22 at 10:00 PM, (7 doses) because the 15 mg had not been delivered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Medical Director on 3/23/22 at 10:30 AM identified that he was not aware that Resident #5 did not receive MS Contin as ordered. Interview (via email) with the DNS on 3/25/22 indicated that he spoke with Resident #5 on 3/14/22 at approximately 12:30 PM to discuss his/her pain medication and their availability, obtaining an alternative pain medication until the MS Contin was delivered and that the resident was currently at his baseline pain level and not experiencing any undue effects from not having the MS Contin. Interview with LPN #4 on 3/25/22 at 2:30 PM identified that she called the pharmacy when they had only sent MS Contin 30mg, and the pharmacy indicated that it was too early to refill the MS Contin 15mg. 4. Resident #6 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder and anxiety. The physician's order dated 11/18/21 directed to administer Alprazolam (antianxiety medication) 2mg three times a day at 6:00 AM, 1:00 PM and 6:00 PM. The quarterly MDS dated [DATE] identified Resident #6 had intact cognition. The corresponding care plan identified Resident #6 received antianxiety medication related to anxiety disorder. Interventions included to administer medications as order, observe for signs or symptoms of anxiety and update the physician with concerns or changes. The March 2022 MAR identified Alprazolam 2mg was not administered on 3/14/22 at 1:00 PM and 6:00 PM because it was not available. A physician ' s order dated 3/14/22 directed to administer Valium (anxiolytic medication) 5 mg at 2:30 PM and 6:00 PM until Resident #6 ' s Alprazolam was delivered from the pharmacy. The March 2022 MAR identified Valium 5mg was administered on 3/14/22 at 2:30 PM and 6:00 PM. Review of the pharmacy delivery sheet identified Resident #6 ' s Alprazolam 2mg was delivered to the facility on [DATE] at 12:50 AM. The March 2022 MAR identified Alprazolam 2mg was administered by LPN #3 on 3/15/22 at 6:00 AM, however, the controlled drug receipt/record/disposition form failed to reflect the Lorazepam 2mg had been removed from the blister pack for administration. Interview with the DNS on 3/22/22 at 4:07 PM identified that APRN #1 was notified on 3/14/22 that Resident #6 did not have any remaining Alprazolam, and an order for Valium 5mg, which the facility had in stock, was obtained to be administered on 3/14/22 at 2:30 PM and 6:00 PM until the Alprazolam was delivered. The DNS identified that although LPN #3 documented that he had administered the Lorazepam 2mg to Resident #6 on 3/15/22 at 6:00 AM, however, the medication had not been removed from the blister pack. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, the DNS provided a medication error report and a written statement via email dated 3/23/22 at 1:45 PM that LPN #3 had inadvertently documented that he administered Alprazolam 2mg on 3/15/22 at 6:00 AM to Resident #6, when he had not. The DNS indicated LPN #3 stated he did not perform the rights of medication administration. Subsequent to surveyor inquiry, Resident #6 and the Medial Director were made aware of the medication omission. Interview with APRN #1 on 3/23/22 at 10:00 AM identified that he was notified on 3/14/22 that Resident #6 did not have Alprazolam in stock, so he ordered Valium 5mg to be given at 2:30 PM and 6:00 PM that day until the Alprazolam was delivered. APRN #1 was not aware that LPN #3 documented that he had administered the Lorazepam 2mg to Resident #6 on 3/15/22 at 6:00 AM, however, the medication had not been removed from the blister pack. Interview with the Medical Director on 3/23/22 at 10:30 AM identified that he was not aware that Resident #6 missed a dose of Alprazolam 2mg on 3/15/22 at 6:00 AM Review of the medication administration policy directed if a medication is not available, it is the nurse ' s responsibility to try to procure the medication and any missed doses must be reported to the responsible party, Medical Director/APRN, shift supervisor and must be documented in Matrix along with all attempts to obtain the medication. Review of the medication reorder policy directed when a medication has 8 days left in supply the charge nurse is to request a refill utilizing the resupply button located in the electronic medication administration record. If a medication is down to 3 days left in supply, the charge nurse will contact the pharmacy to get an expected delivery date, and if the medication does not arrive and a dose is due, the charge nurse will contact the pharmacy and document the reason for delay in delivery, contact MD/APRN for alternative orders and write a progress note to document follow-up. 5. Resident #8 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, chronic kidney disease, stage 4, major depressive disorder. A physician's order dated 3/9/21 directed to administer Metformin 500mg tablet (give two tablets (1000mg) twice daily at 10:00 AM, and 6:00 PM. The care plan dated 11/22/21 identified the resident was at increased risk for alteration in nutritional status due to diabetes. The quarterly MDS dated [DATE] identified Resident #8 had moderately impaired cognition and required extensive assistance with personal hygiene. A physician's order dated 2/11/22 directed to administer Lantus Solostar U-100 Insulin (insulin glargine) 22 units subcutaneous once a day at 8:00 PM. A physician's order dated 3/17/22 directed to check the residents blood sugar once a day at 6:00 AM. Review of the March 2022 MAR identified on 3/27/22 at 6:00 AM Resident #8 ' s blood sugar was documented at 559 mg/dl (normal range is 70 - 100 mg/dl). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075397	A. Building B. Wing	04/27/2022

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes dated 3/8/22 - 4/11/22 failed to reflect that the physician, APRN or resident representative had been notified on 3/27/22 that Resident #8 ' s blood sugar at 6:00 AM was 559 mg/dl. Further, there was no documentation that Resident #8 had been assessed at that time due to the hyperglycemia. Review of the March 2022 MAR identified on 3/28/22 at 6:00 AM Resident #8 ' s blood sugar was documented at 528 mg/dl (normal range is 70 - 100 mg/dl). Review of the progress notes dated 3/28/22 at 6:40 AM identified Resident #8 ' s blood sugar was 528 mg/dl, the resident was alert and responsive with no signs and symptoms of hyperglycemia and the physician was paged. Review of the progress notes dated 3/28/22 at 9:11 AM identified the ADNS notified the physician that Resident #8 ' s blood sugar was 528 mg/dl at 6:00 AM. Physician's orders dated 3/28/22 directed to administer Humalog Pen Insulin, Insulin Lispro (fast acting Insulin) 100 unit/ml, per Sliding Scale before meals; 7:30 AM, 11:30 AM, and 5:00 PM. If blood sugar is less than 80 mg/dl, call the physician. If blood sugar is 200 mg/dl to 249 mg/dl, give 2 units. If blood sugar is 250 mg/dl to 300 mg/dl, give 4 units. If blood sugar is 301 mg/dl to 350 mg/dl, give 6 units. If blood sugar is 351mg/dl to 400 mg/dl, give 8 units. If blood sugar is greater than 400 mg/dl, give 10 units and call the physician. Further, the physician ' s order directed to administer Lantus Solostar U-100 Insulin (long acting Insulin), 100 unit/ml, give 28 units daily at 8:00 PM. Resident responsible for self. Review of the March 2022 MAR failed to reflect that the order dated 3/28/22 at 9:11 AM for Insulin Sliding Scale coverage 3 times daily, and Insulin 28 units at hour of sleep had not been implemented at that time on 3/28/22 at 9:11 AM, and Resident #8 was without the benefit of Sliding Scale Insulin coverage for his/her blood sugar of 528 mg/dl at 6:00 AM. Review of the March 2022 MAR identified on 3/28/22 at 11:30 AM, Resident #8 ' s blood sugar was 489 mg/dl (this is in conflict with the blood sugar reading of high) and the resident received 10 units of Sliding Scale Insulin. Review of the March 2022 MAR identified Sliding Scale Insulin coverage of 10 units was administered on 3/28/22 at 12:00 PM. (This is in addition to the 10 units Insulin that was given at 11:30 AM). Review of the March 2022 [DATE]/28/22 at 12:00 PM identified the resident ' s blood sugar was 587 mg/dl. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse ' s note dated 3/28/22 at 12:44 PM identified Resident #8 ' s blood sugar registered high. Subsequently, the APRN was notified and ordered a one-time additional dose of Humalog 10 units. Review of the March 2022 [DATE]/28/22 at 2:00 PM identified the resident ' s blood sugar was 487 mg/dl. Interview with MD #1 on 4/13/22 at 8:47 AM identified he was not aware Resident #8 ' s blood sugar on Sunday 3/27/22 at 6:00 AM was 559 mg/dl. MD #1 indicated he or the APRN should have been notified when the resident ' blood sugar was elevated. Additionally, MD #1 indicated he was aware of the resident ' s increase blood sugar on Monday 3/28/22 at 6:00 AM of 528 mg/dl and gave a new order to the ADNS for the Sliding Scale. MD #1 indicated that the sliding scale Insulin should have been administered immediately at the time of the order on 3/28/22 at 9:11 AM. Interview with LPN #13 on 4/13/22 at 11:38 AM identified she works on the 7:00 AM - 3:00 PM shift and indicated on 3/28/22 she received report from LPN #14 that Resident #8 ' s blood sugar was high, and the supervisor/(ADNS) was waiting for the physician to call back. LPN #13 indicated she received report that the ADNS had spoken to the physician and new order for a sliding scale was obtained, starting at 200 mg/dl and additional Insulin at 8:00 PM. LPN #13 indicated she was in the middle of passing out medication when the ADNS gave her the new orders for Insulin and she did not document the orders right away. LPN #13 indicated she was going to check Resident #8 ' s blood sugar at 11:30 AM when she does her rounds for blood sugar checks. LPN #13 indicated around 11:30 AM, RN #1 requested a blood sugar check on Resident #8 and the glucometer reading registered high. LPN #13 indicated she can't remember the details exactly what happened or why she documented that Resident #8 ' s blood sugar was 489 mg/dl at 11:30 AM. LPN #13 identified she administered 10 units of Sliding Scale Insulin coverage and notified the APRN at that time. LPN #13 indicated Resident #8 ' s blood sugar at 12:00 PM was 587 mg/dl and the APRN gave an order to administer an additional 10 units of Insulin coverage and recheck the blood sugar in 2 hours at 2:00 PM. At 2:00 PM Resident #8 ' s blood sugar was 487 mg/dl and was given additional coverage of 6 units of insulin. Interview and review of the clinical record with the ADNS on 4/13/22 at 12:45 PM identified she was the supervisor on duty on 3/27/22 from 7:00 PM - 7:00 AM, and the next morning (3/28/22). The ADNS indicated on 3/28/22 at 6:00 AM she was not notified that Resident #8 ' s blood sugar was 528 mg/dl. The ADNS indicated she ran a report on the computer between 7:00 AM and 8:00 AM and the report indicated Resident #8 ' s blood sugar was 528 mg/dl. The ADNS indicated she called the physician at that time and an assessment of Resident #8 for signs and symptoms of hyperglycemia was completed. The ADNS indicated as she was leaving around 8:30 AM the physician returned the call and was updated on the elevated blood sugar. The ADNS indicated she wrote the new orders on a piece of paper and handed the paper to LPN #13 and gave LPN #13 a quick report. The ADNS indicated she also gave an update to the supervisor on duty. The ADNS indicated she documented her notes at 9:11 AM when she arrived at home. Interview with APRN #1 on 4/13/22 at 12:57 PM identified he was not aware that Resident #8 ' s blood sugar on 3/27/22 at 6:00 AM was 559 mg/dl. APRN #1 indicated he did not receive a phone call from RN #2 or LPN #12. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #14 on 4/14/22 at 10:27 AM identified she has been working at the facility through the agency for approximately one month. LPN #14 indicated on 3/28/22 Resident #8 ' s blood sugar at 6:00 AM was 528 mg/dl and Resident #8 did not have an order for insulin coverage. LPN #14 identified she notified the ADNS regarding the 6:00 AM blood sugar of 528 mg/dl but she did not notify the responsible party. LPN #14 indicated she was unable to document on Resident #8 because she was not trained or oriented on the computer system that the facility uses. LPN #4 indicated that she has not documented whenever she works at the facility. Interview with RN #2 on 4/18/22 at 12:01 PM identified LPN #12 did not report to him that Resident #8 had a blood sugar of 559 on 3/27/22 at 6:00 AM. RN #2 indicated the expectation of the facility is that the charge nurse is to notify the RN supervisor and the RN supervisor will assess the resident for signs and symptoms of hyperglycemia and notify the MD or APRN. RN #2 indicated the charge nurse is responsible to notify the responsible party with any changes in condition during their shift. Interview with LPN #12 on 4/19/22 at 9:09 AM identified she is employed through the agency and her first day at the facility was on 3/26/22. LPN #12 indicated she worked a double shift on the 3:00 PM - 11:00 PM shift and the 11:00 PM - 7:00 AM shift. LPN #12 indicated she cannot remember the residents on the unit and do not remember if any residents had increase blood sugar level. LPN #12 indicated that she did not notify the supervisor/MD/APRN or the responsible party regarding any increase blood sugar on 3/27/22 at 6:00 AM. LPN #12 indicated she did not document nurse's notes during her double shift and indicated the facility did not orient or train her on how to use the computer system. LPN #12 indicated she signed off when she administered medications. She indicated the facility said they were going to train her on the computer system, and they never did. LPN #12 indicated she received a phone call from the corporate staff at the facility regarding Resident #8 ' s blood sugar. LPN #12 indicated she told him that she does not know the residents by name. Review of the change of condition policy directed to ensure that changes in resident's conditions are reported to providers and families/emergency contacts in a timely fashion. To ensure that residents' changes of condition are assessed and documented properly. Documentation will be noted in the resident's medical record. 6. Resident #9 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, diabetes, and peripheral vascular disease. Review of the resident census form identified Resident #9 was hospitalized on [DATE]. The discharge tracking MDS dated [DATE] identified Resident #9 had an unplanned discharged to the hospital, return anticipated. Review of the hospital discharge summary dated 3/6/22 at 2:06 PM identified Resident #9 was discharged from the hospital with a stage II pressure injury to the left buttock. Review of the resident census form identified Resident #9 was readmitted from the hospital to the facility on [DATE]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Braden Scale (pressure ulcer risk assessment) dated 3/6/22 at 5:57 PM identified Resident #9's sensory perception was completely limited, he/she was unresponsive to painful stimuli due to diminished level of consciousness or sedation, the resident's skin was constantly moist, he/she was bedfast with very limited mobility and required moderate to maximum assistance with moving. A physician's order dated 3/6/22 directed to complete a weekly skin check on shower day (Monday during the 7:00 AM - 3:00 PM shift) and transfer the resident out of bed via a hoyer to the wheelchair. Further, the orders directed to cleanse the left buttocks wound with normal saline followed by foam dressing daily during the 3:00 PM - 11:00 PM shift. A nurse's note dated 3/6/22 at 6:49 PM identified Resident #9 returned to the facility at 4:06 PM via stretcher. A body audit was performed, and a small abrasion was noted to the left buttock. A dry clean dressing was applied. The care plan dated 3/7/22 identified Resident #9 requires assistance in all ADL's related to severe cognitive impairment and muscle weakness. Interventions included to transfer the resident out of bed with the assistance of 2, bed mobility with the assistance of 2, assistance of 1 with toileting, and turn and reposition every 2 hours and as needed. A readmission nutrition assessment dated [DATE] at 11:42 AM identified Resident #9 had an abrasion to the left buttock. The care plans dated 3/7/22 - 3/17/22 failed to reflect the residents skin integrity or measures and interventions to address such. A wound physician's note dated 3/8/22 identified Resident #9 was seen as a consultation for evaluation of wounds. Location: Coccyx first evaluated on 3/8/22. Consult for Resident #9 with a reported open wound along the coccyx. No wounds noted on evaluation today. The admission MDS dated [DATE] identified Resident #9 had severely impaired cognition, required total 2-person assistance with bed mobility, transfers, toilet use, and personal hygiene. Additionally, Resident #9 was always incontinent of urine and bowel, was at risk of developing pressure ulcers, had a pressure reducing device for bed, turning and repositioning prog [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #2) reviewed for dignity, the facility failed to report an allegation of verbal mistreatment according to established requirements. The findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included dementia without behavioral disturbance, schizoaffective disorder, anxiety disorder, psychosis, and depressive disorder. The quarterly MDS dated [DATE] identified Resident #2 had moderately impaired cognition and required limited assistance with personal hygiene. Interview with RN #1 on 3/23/22 at 3:23 PM identified while in the facility on 3/10/22 between 12:00 PM and 1:00 PM she observed NA #1 rolling her eyes when NA #1 saw Resident #2 in the hallway by the patio exit door. RN #1 indicated she explained to NA #1 that Resident #2 would like to go out to the patio for his/her smoke break. RN #1 indicated she observed NA #1 with her hand out (in a stop gesture) toward the resident and said (I can't even deal with him/her (meaning Resident #2) in front of the resident. RN #1 indicated NA #1 stated Resident #2 is too much for her and that the resident kept asking her questions when Resident #2 is out during smoking break. NA #1 stated that there are too many residents out there during smoking break for one nurse's aide to do smoking alone. RN #1 indicated she spoke to SW #1 who stated that NA #1 is always like that. RN #1 indicated she reported the incident to the Acting DNS and the Administrator on 3/10/22. Interview with SW #1 on 3/23/22 at 3:27 PM identified she was aware of the allegation of verbal mistreatment and indicated that on 3/10/22 when she and RN #1 walked off the elevator Resident #2 was approaching the patio and NA #1 was standing in the door way and said to Resident #2 (you need to bring a nurse's aide down when you come to smoke and I'm not letting you smoke). SW #1 indicated in the past when NA #1 had an issue on the patio during smoking break NA #1 would come and report any issues. SW #1 indicated she did not report the incident to the Acting DNS or the Administrator. Interview with the Acting DNS on 3/23/22 at 3:35 PM identified he was aware of the allegation of verbal mistreatment when RN #1 reported the incident to him. The Acting DNS indicated he did not report the alleged allegation to the state agency. Interview with NA #1 on 4/4/22 at 10:00 AM identified she does not remember the day the incident happened. NA #1 indicated she does not remember being unprofessional and using her hand when she spoke to Resident #2. NA #1 indicated she told Resident #2 that she needed to go and get a nurse's aide if she wanted to smoke. NA #1 indicated the first time she heard about the incident is when the facility asked her to write a statement on 3/23/22. NA #1 indicated the facility did not in-service her regarding the incident. NA #1 indicated she did not report the incident to the Acting DNS. NA #1 indicated SW #1 was present during this incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility resident rights policy identified it is the policy of the facility to provide care and services in accordance with the Resident [NAME] of Rights as outlined by the Federal Nursing Home Reform Law. The Resident [NAME] of Rights is outlines as follows: You have the right to be treated with consideration, respect and full recognition of your dignity and individuality. You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. Review of the facility resident abuse policy identified mistreatment, neglect, exploitation, misappropriation of resident property, and retaliation. To ensure that all staff know their responsibility in identifying and reporting any type of abuse, mistreatment, neglect, exploitation, misappropriation of property, and retaliation as per state and federal guidelines. Verbal abuse: defined as the intentional use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age: ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see their family again. Mistreatment: the inappropriate treatment or exploitation of a resident. Review of the facility resident abuse policy identified internal reporting: All staff will report to their supervisor any allegations or incidents of all types of resident abuse, including injuries of unknown origin. Any supervisor receiving such a report will contact the DNS or ADNS immediately. The DNS or ADNS will notify the Administrator as soon as possible after receiving the report, within two (2) hours. Immediate reporting responsibilities: Any allegation or incident of abuse, neglect, mistreatment, exploitation, misappropriation of resident property, or retaliation will be reported to DPH online with the FLIS portal with two (2) hours. This report will be made by the DNS, ADNS, or Administrator. The facility failed to report the allegation of verbal mistreatment to the state agency according to established requirements.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #2) reviewed for dignity, the facility failed to fully investigate an allegation of verbal mistreatment according to established requirements. The findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included dementia without behavioral disturbance, schizoaffective disorder, anxiety disorder, psychosis, and depressive disorder. The quarterly MDS dated [DATE] identified Resident #2 had moderately impaired cognition and required limited assistance with personal hygiene. Interview with RN #1 on 3/23/22 at 3:23 PM identified while in the facility on 3/10/22 between 12:00 PM and 1:00 PM she observed NA #1 rolling her eyes when NA #1 saw Resident #2 in the hallway by the patio exit door. RN #1 indicated she explained to NA #1 that Resident #2 would like to go out to the patio for his/her smoke break. RN #1 indicated she observed NA #1 with her hand out (in a stop gesture) toward the resident and said (I can't even deal with him/her (meaning Resident #2) in front of the resident. RN #1 indicated NA #1 stated Resident #2 is too much for her and that the resident kept asking her questions when Resident #2 is out during smoking break. NA #1 stated that there are too many residents out there during smoking break for one nurse's aide to do smoking alone. RN #1 indicated she spoke to SW #1 who stated that NA #1 is always like that. RN #1 indicated she reported the incident to the Acting DNS and the Administrator on 3/10/22. Interview with SW #1 on 3/23/22 at 3:27 PM identified she was aware of the allegation of verbal mistreatment and indicated that on 3/10/22 when she and RN #1 walked off the elevator Resident #2 was approaching the patio and NA #1 was standing in the door way and said to Resident #2 (you need to bring a nurse's aide down when you come to smoke and I'm not letting you smoke). SW #1 indicated in the past when NA #1 had an issue on the patio during smoking break NA #1 would come and report any issues. SW #1 indicated she did not report the incident to the Acting DNS or the Administrator. Interview with the Acting DNS on 3/23/22 at 3:35 PM identified he was aware of the allegation of verbal mistreatment when RN #1 reported the incident to him. The Acting DNS indicated he did not report the alleged allegation to the state agency. Interview with NA #1 on 4/4/22 at 10:00 AM identified she does not remember the day the incident happened. NA #1 indicated she does not remember being unprofessional and using her hand when she spoke to Resident #2. NA #1 indicated she told Resident #2 that she needed to go and get a nurse's aide if she wanted to smoke. NA #1 indicated the first time she heard about the incident is when the facility asked her to write a statement on 3/23/22. NA #1 indicated the facility did not in-service her regarding the incident. NA #1 indicated she did not report the incident to the Acting DNS. NA #1 indicated SW #1 was present during this incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility resident rights policy identified it is the policy of the facility to provide care and services in accordance with the Resident [NAME] of Rights as outlined by the Federal Nursing Home Reform Law. The Resident [NAME] of Rights is outlines as follows: You have the right to be treated with consideration, respect and full recognition of your dignity and individuality. You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. Review of the facility resident abuse policy identified mistreatment, neglect, exploitation, misappropriation of resident property, and retaliation. To ensure that all staff know their responsibility in identifying and reporting any type of abuse, mistreatment, neglect, exploitation, misappropriation of property, and retaliation as per state and federal guidelines. Verbal abuse: defined as the intentional use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age: ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see their family again. Mistreatment: the inappropriate treatment or exploitation of a resident. Review of the facility resident abuse policy identified internal reporting: All staff will report to their supervisor any allegations or incidents of all types of resident abuse, including injuries of unknown origin. Any supervisor receiving such a report will contact the DNS or ADNS immediately. The DNS or ADNS will notify the Administrator as soon as possible after receiving the report, within two (2) hours. Immediate reporting responsibilities: Any allegation or incident of abuse, neglect, mistreatment, exploitation, misappropriation of resident property, or retaliation will be reported to DPH online with the FLIS portal with two (2) hours. This report will be made by the DNS, ADNS, or Administrator. The facility failed to fully investigate an allegation of verbal mistreatment to the state agency according to established requirements.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, and facility interviews for 1 of 2 residents (Resident #8) reviewed for diabetic management, the facility failed to develop a comprehensive person-centered care plan related to the diagnoses of diabetes. The findings include: Resident #8 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, chronic kidney disease, stage 4, major depressive disorder. A physician's order dated 3/9/21 directed to administer Metformin 500mg tablet (give two tablets (1000mg) twice daily at 10:00 AM, and 6:00 PM. The care plan dated 11/22/21 identified the resident was at increased risk for alteration in nutritional status due to diabetes. The quarterly MDS dated [DATE] identified Resident #8 had moderately impaired cognition and required extensive assistance with personal hygiene. A physician's order dated 2/11/22 directed to administer Lantus Solostar U-100 Insulin (insulin glargine) 22 units subcutaneous once a day at 8:00 PM. A physician's order dated 3/17/22 directed to check the residents blood sugar once a day at 6:00 AM. Review of the March 2022 MAR identified on 3/27/22 at 6:00 AM Resident #8 ' s blood sugar was documented at 559 mg/dl (normal range is 70 - 100 mg/dl). Review of the progress notes dated 3/8/22 - 4/11/22 failed to reflect that the physician, APRN or resident representative had been notified on 3/27/22 that Resident #8 ' s blood sugar at 6:00 AM was 559 mg/dl. Further, there was no documentation that Resident #8 had been assessed at that time due to the hyperglycemia. Review of the March 2022 MAR identified on 3/28/22 at 6:00 AM Resident #8 ' s blood sugar was documented at 528 mg/dl (normal range is 70 - 100 mg/dl). Review of the progress notes dated 3/28/22 at 6:40 AM identified Resident #8 ' s blood sugar was 528 mg/dl, the resident was alert and responsive with no signs and symptoms of hyperglycemia and the physician was paged. Review of the progress notes dated 3/28/22 at 9:11 AM identified the ADNS notified the physician that Resident #8 ' s blood sugar was 528 mg/dl at 6:00 AM. Physician's orders dated 3/28/22 directed to administer Humalog Pen Insulin, Insulin Lispro (fast acting Insulin) 100 unit/ml, per Sliding Scale before meals; 7:30 AM, 11:30 AM, and 5:00 PM. (continued on next page)

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	075397	A. Building B. Wing	04/27/2022

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If blood sugar is less than 80 mg/dl, call the physician. If blood sugar is 200 mg/dl to 249 mg/dl, give 2 units. If blood sugar is 250 mg/dl to 300 mg/dl, give 4 units. If blood sugar is 301 mg/dl to 350 mg/dl, give 6 units. If blood sugar is 351mg/dl to 400 mg/dl, give 8 units. If blood sugar is greater than 400 mg/dl, give 10 units and call the physician. Further, the physician ' s order directed to administer Lantus Solostar U-100 Insulin (long acting Insulin), 100 unit/ml, give 28 units daily at 8:00 PM. Resident responsible for self. Review of the March 2022 MAR failed to reflect that the order dated 3/28/22 at 9:11 AM for Insulin Sliding Scale coverage 3 times daily, and Insulin 28 units at hour of sleep had not been implemented at that time on 3/28/22 at 9:11 AM, and Resident #8 was without the benefit of Sliding Scale Insulin coverage for his/her blood sugar of 528 mg/dl at 6:00 AM. Review of the March 2022 MAR identified on 3/28/22 at 11:30 AM, Resident #8 ' s blood sugar was 489 mg/dl (this is in conflict with the blood sugar reading of high) and the resident received 10 units of Sliding Scale Insulin. Review of the March 2022 MAR identified Sliding Scale Insulin coverage of 10 units was administered on 3/28/22 at 12:00 PM. (This is in addition to the 10 units Insulin that was given at 11:30 AM). Review of the March 2022 [DATE]/28/22 at 12:00 PM identified the resident ' s blood sugar was 587 mg/dl. Review of the nurse ' s note dated 3/28/22 at 12:44 PM identified Resident #8 ' s blood sugar registered high. Subsequently, the APRN was notified and ordered a one-time additional dose of Humalog 10 units. Review of the March 2022 [DATE]/28/22 at 2:00 PM identified the resident ' s blood sugar was 487 mg/dl. Interview with MD #1 on 4/13/22 at 8:47 AM identified he was not aware Resident #8 ' s blood sugar on Sunday 3/27/22 at 6:00 AM was 559 mg/dl. MD #1 indicated he or the APRN should have been notified when the resident ' blood sugar was elevated. Additionally, MD #1 indicated he was aware of the resident ' s increase blood sugar on Monday 3/28/22 at 6:00 AM of 528 mg/dl and gave a new order to the ADNS for the Sliding Scale. MD #1 indicated that the sliding scale Insulin should have been administered immediately at the time of the order on 3/28/22 at 9:11 AM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the ADNS on 4/13/22 at 12:45 PM identified she was the supervisor on duty on 3/27/22 from 7:00 PM - 7:00 AM, and the next morning (3/28/22). The ADNS indicated on 3/28/22 at 6:00 AM she was not notified that Resident #8 ' s blood sugar was 528 mg/dl. The ADNS indicated she ran a report on the computer between 7:00 AM and 8:00 AM and the report indicated Resident #8 ' s blood sugar was 528 mg/dl. The ADNS indicated she called the physician at that time and an assessment of Resident #8 for signs and symptoms of hyperglycemia was completed. The ADNS indicated as she was leaving around 8:30 AM the physician returned the call and was updated on the elevated blood sugar. The ADNS indicated she wrote the new orders on a piece of paper and handed the paper to LPN #13 and gave LPN #13 a quick report. The ADNS indicated she also gave an update to the supervisor on duty. The ADNS indicated she documented her notes at 9:11 AM when she arrived at home. Interview with APRN #1 on 4/13/22 at 12:57 PM identified he was not aware that Resident #8 ' s blood sugar on 3/27/22 at 6:00 AM was 559 mg/dl. APRN #1 indicated he did not receive a phone call from RN #2 or LPN #12. Interview with LPN #14 on 4/14/22 at 10:27 AM identified she has been working at the facility through the agency for approximately one month. LPN #14 indicated on 3/28/22 Resident #8 ' s blood sugar at 6:00 AM was 528 mg/dl and Resident #8 did not have an order for insulin coverage. LPN #14 identified she notified the ADNS regarding the 6:00 AM blood sugar of 528 mg/dl but she did not notify the responsible party. LPN #14 indicated she was unable to document on Resident #8 because she was not trained or oriented on the computer system that the facility uses. LPN #4 indicated that she has not documented whenever she works at the facility. Interview with RN #2 on 4/18/22 at 12:01 PM identified LPN #12 did not report to him that Resident #8 had a blood sugar of 559 on 3/27/22 at 6:00 AM. RN #2 indicated the expectation of the facility is that the charge nurse is to notify the RN supervisor and the RN supervisor will assess the resident for signs and symptoms of hyperglycemia and notify the MD or APRN. RN #2 indicated the charge nurse is responsible to notify the responsible party with any changes in condition during their shift. Interview and review of the clinical record with the ADNS on 4/13/22 at 1:00 PM indicated she was not aware Resident #8 did not have a comprehensive care plan related to type 2 diabetes mellitus. The ADNS indicated it is the responsibility of the admission nurse to initiate the comprehensive care plan on admission and identified she initiated a care plan on 3/29/22 to address Resident #8 abnormal blood glucose levels secondary to diabetes. Interview with LPN #13 on 4/13/22 at 11:38 AM identified she was not aware that the Resident #8 did not have a care plan to address the diagnoses of diabetes mellitus. LPN #13 indicated it is the responsibility of the admission nurse to initiate the care plan on admission. Review of the care plans, comprehensive person-centered policy identified a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35682 Based on review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #11) reviewed for leave of absence (LOA), the facility failed to ensure the care plan was reviewed and revised to include the resident ' s history of substance abuse and leave of absence (LOA) protocol with appropriate interventions. The findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, alcohol abuse, opioid abuse and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #11 had intact cognition, required limited assistance with all activities of daily living and ate independently. The care plan dated 1/26/22 failed to reflect Resident #11's diagnoses of alcohol and opioid abuse. Review of the care plan in the electronic medical record system, (EMR) which was used at the time of resident's admission (October 2021) and prior to the facility's change to a new EMR, identified the resident had a history of alcohol and opioid abuse. However, after the change to a different EMR, the care plan did not include the resident's history of alcohol and opioid abuse. Additionally, when the resident began having independent LOA's, the care plan was not updated to reflect this change in status. A physician's order dated 3/27/22 directed Resident #11 may go on pass with medications. Review of Resident #11's Leave of Absence Log identified the resident went out on LOA on the following dates and times: a. 3/27/22 at 1:16 PM; destination, store; anticipated time of return: supper; time returned: 3:06 PM. b. 4/1/22 at 9:15 AM; destination: DSS; anticipated time of return: 4-6 PM; time returned: 12:25 PM. c. 4/2/22 at 10:00 AM; destination: Store; anticipated time of return: 2-4 PM; time returned: 1:40 PM. d. 4/4/22 at 10:32 AM; destination: DSS; anticipated time of return: 4-5 PM; time returned: 2:50 PM. e. 4/5/22 at 10:34 AM; destination: Store; anticipated time of return: 2-4 PM; time returned: 2:40 PM. f. 4/7/22 at 10:35 AM; destination: Store; anticipated time of return: 2:30-4 PM. A nurse ' s note, written by LPN #1, dated 4/7/22 at 3:08 PM identified the resident left the facility LOA at 10:30 AM. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note, written by LPN #1, dated 4/7/22 at 9:48 PM indicated she reported to the RN supervisor at 8:00 PM that Resident #11 had not returned from his/her LOA. A nurse's note written by the RN supervisor, (RN #2), on 4/7/22 at 10:00 PM identified he was informed by LPN #1 that Resident #11 had not returned from LOA. The note indicated the resident had no emergency contact or personal phone contact number and that resident's BIMS score was 15 and he/she was cognitively intact. RN #2 notified the Social Worker, Administrator, DNS, and also contacted the closest hospital, who had no record of the resident. RN #2 contacted the police department to report that the resident had not returned from LOA at the anticipated time. A nurse's note written by RN #2 on 4/7/22 at 10:49 PM identified a police officer arrived at the facility to gather information about Resident #11 and provide case number. A nurse's note, written by RN #2, on 4/8/22 at 3:15 AM identified he received a call from the police department indicating the resident had arrived at hospital emergency room (ER) at 11:00 PM and was medically cleared. The hospital nurse reported to RN #2 that the resident had arrived to the ER with complaints of back pain, right wrist pain and bilateral foot pain sustained after the resident indicated he/she had been dragged by a passenger of a car for two blocks while reaching into the car for a lighter. Diagnostic tests, including x-rays and CT scans showed no findings and the resident was cleared for discharge back to the facility. Resident #11 returned to the facility on [DATE] at 5:00 AM and was thoroughly assessed by RN #2. Hospital discharge documentation was reviewed by RN #2, who noted resident's urine screen was positive for cocaine, which had not been communicated during hospital report. Resident #11 ' s belongings were searched for contraband with no findings. Review of APRN #1's progress note dated 4/8/22 at 9:25 AM identified Resident #11 was seen for follow-up after the ER visit. Resident #11 was out on LOA 4/7/22, went to ER for being dragged by a car for 2 blocks, ankle run over by car, was evaluated at ER and was found to be positive for cocaine. The APRN identified the resident was sleeping, in no distress, when awoken, and denied pain. The note indicated although the resident denied cocaine use, the ER testing indicated positive result. Subsequent to the incident on 4/7/22, the care plan was updated to include the resident's history of alcohol and opioid abuse, but there was no documentation added to the care plan related to LOA status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 4/27/22 at 11:05 AM identified that he was the RN supervisor on 4/7/22 on the 3:00 PM - 11:00 PM shift and 11:00 PM - 7:00 AM shift. RN #2 identified he usually receives report from the charge nurses when making rounds, who will inform him of any concerns. RN #2 identified he was not aware that Resident #11 was out on LOA until LPN #1 informed him at approximately 8:00 PM that the resident had been expected to return from LOA between 2:30 PM - 4:00 PM. RN #2 identified the resident did not have a phone or anyone listed as contacts in the record so there was no way to contact the resident. RN #2 identified the resident had been out on several LOA's recently and had always returned before expected and with no incident. RN#2 identified he contacted the Administrator, DNS, Social Worker and the police and the closest hospital to see if the resident was there. RN #2 identified the police came to the facility to obtain more information at approximately 10:00 PM. RN #2 indicated he received a call from the police department informing him that the resident had arrived at the hospital ER at 11:00 PM after being injured when dragged by a car while reaching in through the passenger side window. RN #2 identified he received a report from the hospital prior to the resident being sent back to the facility however was not informed of resident ' s positive drug screen for cocaine until reviewing hospital paperwork once resident arrived at the facility. RN #2 identified he fully assessed the resident upon return and completed a search of resident and his belongings which was negative for contraband. Interview with LPN #1 on 4/27/22 at 11:40 AM identified that she was Resident #11's charge nurse on the 7:00 AM - 3:00 PM shift and the 3:00 PM - 11:00 PM shift on 4/7/22. LPN #1 identified that prior to the pandemic, the LOA logs for residents were kept at the nurse's station and residents would fill out the log at the time of departure, documenting where they were going and what time they were expected to return. LPN #1 identified during the pandemic when visitation changed, the LOA book was moved from the units down to reception. The nurse on the floor would call reception to let them know that a resident was on their way down and going out LOA so she could allow resident to exit facility since the doors were kept locked. LPN #1 identified on 4/7/22, although she was aware the resident had gone out LOA in the morning, she could not recall if the resident had informed her when he was expected to return but around 8:00 PM, when she realized resident had not returned, she notified RN #2, the nursing supervisor. LPN #1 identified the resident walked independently, was alert and oriented and responsible for himself. LPN #1 identified that because the LOA log was not on the units, unless you speak with the resident when they are leaving it's difficult to keep track of when they are due to return. LPN #1 identified she was not concerned about the resident because he/she had been out on LOA several times recently and never had any issues. LPN #1 identified the resident had not had any violations regarding smoking or contraband and searches upon return have always been negative. LPN #1 identified RN #2 notified the APRN, Administrator, DNS, Social Worker, police and called the local hospital to see if the resident was there. Interview with the Administrator on 4/27/22 at 2:30 PM identified although there was discussion related to resident's request for LOA, prior to obtaining the physician's order, they were unable to find any documentation to support that a LOA risk assessment was completed for Resident #11. The Administrator identified corporate staff sent an email (4/6/22) with revisions and instructions that they were currently rolling out re LOA. the Administrator identified they have held a meeting with the resident council to inform the residents of the changes, which include needing to have someone with them when they go out LOA. They have also moved the LOA sign out logs for residents back to the units instead of maintaining the log in reception. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/27/22 at 2:45 PM identified that she would have expected LPN #1 to have realized by dinner time (5:00 PM) that the resident had not returned from LOA and to have informed the nursing supervisor. The DNS identified she was aware how busy the nurses were, but resident's LOA still should have been identified before 8:00 PM, 4 hours after the resident was expected to return. The DNS further identified the resident should have had a care plan for LOA privileges, which included the need for a risk assessment, search of belongings upon return and following policy. Interview with MD #4 on 4/28/22 at 1:00 PM identified she was Resident #11's physician. Although MD #4 indicated she gave the order for LOA privileges for Resident #11, she did not recall the details of the discussion. MD #4 identified that generally, LOA privileges were granted to residents who were cognitively intact, responsible for themselves and who were not at risk of harming themselves or others. Review of the Leave of Absence Policy last revised on 3/23/22 identified a therapeutic leave of absence occurs when a resident leaves the nursing facility for an activity that may be considered therapeutic (i.e. visiting with family, trip to the local store, etc.) with a physician's order. It is the policy of the facility to not allow independent LOAs. Residents that are mentally and physically capable may be given a physician' s order for a therapeutic LOA at their request no earlier than fourteen days after admission. LOAs are only granted after medical clearance from the physician, evaluation and clearance by physical therapy and discussion/approval by the interdisciplinary team (IDT). The facility will complete the ADVANCED - LOA RISK ASSESSMENT as an IDT and document the results. Approved residents must notify their charge nurse prior to leaving, sign out on the LOA log on the unit, complete the LOA notification form and provide a copy of the form to the front desk before leaving the building with their responsible party. Residents must return within approximately (2) hours of their anticipated return time or contact the facility to advise the charge nurse of the revised anticipated return time. If the resident/responsible party does not contact the facility, the charge nurse will attempt to contact the resident/responsible party. If the resident cannot be located and he/she does not return by midnight, the LOA becomes unauthorized, the physician will be notified, and the LOA will be considered a discharge against medical advice. Review of the Leave of Absence Log identified for resident, by signing myself out, I agree that I will return at the stated time. I agree to notify the facility if I will be late. I agree to sign-in when I return. Additionally, I will follow all contraband policies and understand that interventions, including suspension of my LOA privilege, may be put in place to protect me and the safety of others should these policies be violated. For the resident and responsible party, I agree that the facility is not responsible for the resident's health, safety or well-being while he/she is away from the facility on leave of absence.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 2 residents (Resident #7 and 8) reviewed for diabetic management, for Resident #7 the facility failed to have Glucagon (a medication to treat severely low blood sugar), readily available and to administer the Glucagon to Resident #7 to reverse a critically low blood sugar. Additionally, the licensed staff failed to follow standards of practice to treat the resident's hypoglycemia and instead applied ice on the resident body which resulted in the resident becoming hypothermic with a body temperature of 90.9 F (normal body temperature ranges from 97.5 F to 98.9 F). These failures to properly treat Resident #7's hypoglycemia with resulting hypothermia resulted in Immediate Jeopardy. For Resident #8, the facility failed to follow standards of practice when the resident's blood sugar was elevated, and for 4 residents (Residents #3, 4, 5 and 6) reviewed for medication administration, the facility failed to administer medications according to the physician's orders. The findings include: 1. Resident #7 was admitted to the facility on in [DATE] with diagnosis included Type 1 and Type 2 Diabetes Mellitus. The quarterly MDS assessment dated [DATE] identified Resident #7 had intact cognition and was independent with eating with set up only and received insulin injections. Physician ' s orders for [DATE] directed to administer Admelog U-100 Insulin (a fast-acting mealtime insulin): per sliding scale subcutaneous 3 times a day before meals: 6:30 AM, 11:30 AM, and 4:30 PM. If blood sugar is less than 70, call MD. If blood sugar is 150 to 199 give 2 units. If blood sugar is 200 to 249 give 4 units. If blood sugar is 250 to 299 give 6 units. If blood sugar is 300 to 349 give 8 units. If blood sugar is 350 to 399 give 10 units. If blood sugar is greater than 400 call MD/APRN. Physician ' s orders for [DATE] directed to administer Lantus U-100 Insulin (long acting Insulin) 34 units, subcutaneous twice a day: 8:00 AM and 8:00 PM. Additionally, the physician ' s orders directed to administer Metformin (anti-diabetic medication) 500 mg twice daily at 9:00 AM, and 5:30 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan dated [DATE] indicated Resident #7 was at potential nutrition risk related to the diagnosis of Type 2 Diabetes. Interventions included to provide a diet of no-added-salt/no concentrated sweets, monitor blood glucose as ordered and notify the physician if indicated by facility parameters. Review of the [DATE] MAR identified the following; On [DATE] at 6:30 AM Resident #7 had a blood sugar of 110 mg/dl (normal range is 70 - 100 mg/dl) and did not require insulin coverage, and at 8:00 AM the resident received 34 units of Lantus Insulin. The [DATE] MAR identified on [DATE] at 9:00 AM Resident #7 received Metformin 500mg. The [DATE] MAR identified on [DATE] at 11:30 AM Resident #7 had a blood sugar of 194 mg/dl. Resident #7 refused the sliding scale coverage of 2 units. Review of a Cubex (the Cubex System is an automated medication dispensing system) transaction dated [DATE] at 12:56 PM, the ADNS attempted to withdrawal Glucagon 1mg IM from the Cubex machine, but the medication was not able to be obtained. A nurse ' s note identified on [DATE] at approximately 1:15 PM Resident #7 was in bed, unresponsive with his/her eyes opened. The skin was cool and clammy, and the residents blood sugar level was noted to be 40 mg/dl (normal range is 70 - 100 mg/dl). The nursing supervisor was made aware, sugar was given under the resident ' s tongue, and a subsequent blood sugar level was noted to be lower at 33 mg/dl. A nurse ' s note dated [DATE] at 2:15 PM identified the ADNS who was also covering as the RN supervisor, was called to the resident ' s room. The note indicated Resident #7 had low blood sugar (40 mg/dl) around lunch time and was intermittently responsive, sweating with pale skin. One sugar pack was administered under the resident ' s tongue at that time and Resident #7 did swallow. Due to a technical malfunction, the Glucagon in the facility ' s Cubex machine was not able to be accessed. EMS arrived and subsequent to APRN notification, Resident #7 was transferred to the emergency room for an evaluation. A reportable event form dated [DATE] identified Resident #7 had a blood sugar of 40 mg/dl and the nurse attempted to obtain Glucagon from the Cubex machine, but the container would not open. In an effort to keep Resident #7 awake, the nurse placed ice packs on the resident. Upon arrival to the hospital, Resident #7 was noted to be hypothermic with a temperature of 90.9 F. The Administrator was updated, an investigation was immediately initiated including education provided to licensed staff. Glucagon immediately procured from pharmacy for all medication carts, and maintenance was immediately requested for the Cubex machine. Pharmacy representative to come and provide additional insulin education, and all diabetic resident ' s orders were audited, and additional order sets entered as needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A written statement from the Independent Nurse Consultant (RN #1) dated [DATE] identified that at 1:30 PM she overheard the receptionist say 911 is coming. RN #1 indicated upon entering Resident #7 ' s room, the resident was non-responsive and there were 6 nurses standing around the resident ' s bed. LPN #9 reported the residents blood sugar was 34, there was no Glucagon available, and they had given Resident #7 several sugar packets. The residents lunch tray on the bedside table was untouched. RN #1 indicated Resident #7 had a bag of ice on each side of his/her body, LPN #10 was applying ice to the resident ' s chest, and another nurse was giving the resident a sternal rub. RN #1 educated the nurses at that time that ice, and sternal rub are not the appropriate treatment for hypoglycemia. RN #1 indicated EMS arrived at 1:40 PM. At 2:00 PM following Resident #7 ' s departure, RN #1, the Administrator, and the ADNS went to the Cubex machine in the supervisor ' s office. The ADNS indicated the Glucagon IM was in the Cubie (cartridge/drawer). RN #1 and the ADNS attempted 3 times to open the Cubie without success, and the ADNS did not know how to override the Cubex machine. RN #1 indicated at 2:15 PM the pharmacy was called for Glucagon for each of the medication carts The hospital emergency room note dated [DATE] at 3:19 PM identified Resident #7 was found unresponsive at approximately 1:00 PM at the nursing home with a blood sugar of 30 mg/dl. Per EMS attendants, there was ice on Resident #7 to revive the resident. Resident #7 was found with low rectal temperature and placed on Bair Hugger (a convective temperature management system used in a hospital or surgery center to maintain a patient's core body temperature). The hospital admission note dated [DATE] at 5:02 PM identified Resident #7 was admitted for hypothermia and hypoglycemia. Resident #7 was found to be hypoglycemic to 30 mg/dl at the nursing home. Resident was given glucagon and 250 ml of Dextrose 10 fluids intravenously which his/her sugar improved to 80 mg/dl in the emergency room . In the emergency room , Resident #7 was found to be hypothermic to 90.9 Fahrenheit. A written statement from the ADNS dated [DATE] identified she was called to see Resident #7 who had low blood sugar and was on/off unresponsive around lunch time. Resident #7 was sweating with pale skin. The ADNS indicated LPN #9 informed her Resident #7 ' s blood sugar was 40 while LPN #10 went to go and get Glucagon IM. Sugar was given sublingually, and the resident was able to swallow. Blood sugar rechecked and was 33 mg/dl. The ADNS indicated she immediately went to the Cubex machine to get Glucagon IM for administration, and although she was able to open the Cubex drawer, she was unable to open dedicated Glucagon bin due to a malfunction. The ADNS indicated continuously attempting to get Glucagon IM from Cubex with no success. A written statement from LPN #9 dated [DATE] at 5:00 PM indicated at approximately 1:00 PM Resident #7 was incoherent and his/her eyes were opening and closing. LPN #9 checked the resident ' s blood sugar which was noted to be 40 mg/dl. NA #2 stayed with the resident, and a STAT was called. The staff were having a hard time getting the Glucagon out of the Cubex machine and there was none available on the medication carts. LPN #10 was trying to keep Resident #7 from passing out, so she put ice in a plastic bag around the resident. A written statement by LPN #10 dated [DATE] at 5:44 PM identified she heard LPN #9 yell to get Glucagon. LPN #10 went to go and get Glucagon, and staff were having a hard time getting it. LPN #10 indicated Resident #7 was moaning and snoring and LPN #10 indicated she put ice on Resident #7 and performed a sternal rub to keep him/her awake and aroused. LPN #10 indicated she was trying to help the resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of in-service by the ADNS and RN #2 dated [DATE] identified staff were educated on hypoglycemia/hyperglycemia, insulin, blood sugar checks, diabetic resident must have snack at hour of sleep, not applying ice or perform sternal rub when a resident is hypoglycemic, emergency hypoglycemia medication (Glucagon IM, Glucagon Gel, Glucagon tablet). Further the staff were educated on the Cubix machine by the pharmacy. The summary report dated [DATE] identified on [DATE] Resident #7 was transferred to the hospital after a period of unresponsiveness at the facility and was admitted with a diagnosis of hypothermia and hypoglycemia. The facility immediately initiated an investigation and established a timeline. During the investigation, it was determined that a malfunction of the Cubie in the Cubex machine prevented the ADNS from removing the Glucagon. The Cubie has been replaced and is functioning properly. The facility has also taken the following actions as part of a plan of correction related to this event: Charge nurse was provided with individual counseling, discipline, and education about the appropriate management of residents with hypoglycemia. Charge nurse statement revealed that she applied the ice in an effort to keep the resident aroused in the absence of the Glucagon. The nurse was educated that ice application is not an appropriate intervention and she has documented understanding. Licensed staff were provided with education about change of condition, the appropriate management of residents with hypoglycemia and use of the Cubex. Glucagon injectable and glucose tablets immediately ordered from the pharmacy and now available in each medication cart. Inventory of Cubex verified and licensed nurses re-educated on its use. Pharmacy representative to provide additional information about diabetes management. Audit completed of all diabetic residents to ensure appropriateness of orders in EMAR including emergency management interventions. Diabetic order set implemented in EMAR. Facility QAPI implemented to monitor compliance with this plan of correction. Interview with the ADNS on [DATE] at 1:57 PM identified she was the RN supervisor on [DATE] on the 7:00 AM - 3:00 PM shift and indicated LPN #9 called her around lunch about Resident #7 ' s blood sugar which was low at 40 mg/dl. When she arrived at Resident #7 ' s room she observed Resident #7 in bed and LPN #9 trying to stimulate the resident. The ADNS indicated the blood sugar was re-checked with another glucometer machine and the blood sugar result was 33 mg/dl. She indicated Resident #7 was alert, lethargic and attempting to open his/her eyes. The ADNS indicated she went to the supervisor ' s office to the Cubex machine md the drawer opened but the Cubie drawer malfunctioned and would not open to allow access to the IM Glucagon and she was unable to get it. The ADNS indicated she had another nurse attempt to open the Cubex machine, which was unsuccessful, so she directed all the nurses to check their medication carts for Glucagon. The ADNS indicated the facility did not have Glucagon gel or Glucagon IM available in any of the medication carts or in the medication rooms. The ADNS indicated she called the pharmacy account manager and called the pharmacy for STAT Glucagon IM and Glucagon Gel and indicated the pharmacy reported that the Glucagon Gel was on back order so she called another pharmacy. The ADNS indicated when the STAT Glucagon was delivered, she supplied each of the medication carts (6 medication carts) with one Glucagon IM, one Glucagon Gel, and one bottle of Glucagon tablets in a Ziploc bag. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Social Worker #1 on [DATE] at 3:04 PM identified she does not remember the exact time, but it was around lunch time and she went to give Resident #7 his/her lunch tray and the resident was unresponsive in the bed. Social Worker #1 indicated she attempted to wake the resident up, but he/she would not wake up. Social worker #1 indicated she immediately went to get LPN #9 and then continued to pass out the lunch trays. Interview with LPN #9 on [DATE] at 3:25 PM identified at around lunch time Social Worker #1 reported Resident #7 could not be woken up. LPN #9 indicated she immediately went to the room and the resident was lying in the bed with his/her head at the foot of the bed. The resident tried to talk but could not and the skin was clammy to touch. LPN #9 indicated Resident #7 ' s blood sugar was 40 mg/dl and when she looked, the medication cart did not contain Glucagon IM so she asked LPN #10 to check her medication cart which also did not contain Glucagon. LPN #9 indicated LPN #10 ran to get the ADNS who came down and assessed Resident #7 who was in and out of responsiveness. At that point a STAT code was called and the ADNS went to the supervisor ' s office for Glucagon IM however, the Cubie would not open. LPN #9 indicated she had left the room to call EMS and was not in the room when ice was applied to Resident #7. Interview with NA #2 on [DATE] at 4:01 PM indicated Resident #7 told her that he/she had a little something for breakfast and she offered him/her a cold cereal. Interview with the Acting DNS on [DATE] at 4:18 PM indicated he was not in the facility when Resident #7 ' s blood sugar was 40 mg/dl and indicated that he was not aware that the medication carts did not have Glucagon IM. The Acting DNS indicated he came to the facility that evening and the ADNS notified him that the Cubex machine malfunction and she was unable to retrieve the Glucagon IM and the medication carts had no Glucagon IM or Glucagon Gel. The Acting DNS indicated that all the medication carts were supplied with one Glucagon IM, one Glucagon Gel, one bottle of Glucagon tablets and staff were educated on hypoglycemia. Interview with NA #2 on [DATE] at 10:57 AM identified she had given Resident #7 cold cereal and he/she only ate a little bit. Although NA #2 documented the resident 100% of breakfast, the resident only ate a little bit of the breakfast and the little bit of the cold cereal. NA #2 indicated Resident #7 is a picky eater. Interview with LPN #10 on [DATE] at 11:18 AM identified she rechecked Resident #7 ' s blood sugar and it was 33 mg/dl, so she put the ice on the resident to keep him/her aroused and alert because the facility did not have any Glucagon IM. Interview with MD #1 on [DATE] at 8:44 AM identified he was not aware that the facility did not have Glucagon IM or Glucagon Gel available on each medication carts or that staff had put ice on Resident #7 in response to hypoglycemia. MD #1 indicated the expectation is that every medication cart and the medication rooms should have Glucagon IM, and Glucagon Gel for emergencies. MD #1 indicated that the hypothermia was caused by staff placing ice on Resident #7. MD #1 indicated the staff should not have put ice on the resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with MD #2, (Endocrinology) on [DATE] at 1:39 PM identified he only saw Resident #7 once on [DATE] in the hospital. MD #2 indicated he documented that the hypothermia was caused by hypoglycemia because was not aware that bags of ice had been applied to the resident during the hypoglycemic episode to arouse the resident. MD #2 indicated if he was aware that Resident #7 had ice applied to the body, he would have not documented in the note that hypoglycemia can cause mental status changes and be associated with hypothermia as well. MD #2 indicated the reason for the hypothermia would have been because ice was applied to the resident during a hypoglycemic episode. Review of the facility blood glucose policy identified the purpose is to determine the amount of glucose (sugar) present in the blood and assist in the management of diabetes. Review of the facility medication administration policy identified to provide a safe and effective medication management framework to help eliminate any harm that could be caused at any level of the medication management process. To ensure that licensed facility staff will adhere to proper safety precautions in the administration of medications. Review of the insulin administration policy identified to provide guidelines for the safe administration of insulin to residents with diabetes. Documentation: How well the resident tolerated the procedure. Reporting: Notify your supervisor if the resident refuses the insulin injection. Notify the physician if the resident has sign and symptoms of hypoglycemia/hyperglycemia that are not resolved by following the facility protocol for hypoglycemia/hyperglycemia management. Review of the nursing care of the resident with diabetes policy identified diabetes is a disorder in which there is relative or absolute lack of insulin. Among other things, glucose (sugar) from food cannot be taken up by the cells, which results in elevated blood sugar (hyperglycemia) and lack of energy for cellular function. Management of hypoglycemia: For symptomatic (lethargic, drowsy) but responsive (conscious) residents with hypoglycemia (<70 mg/dl or less than the physician-ordered parameter): If he/she is unable to swallow: 1) Immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon, or IV 50% dextrose, per facility protocol; 2) Recheck blood glucose in 15 minutes; and 3) Repeat protocol if indicated and recheck blood glucose in 15 minutes. Remain with the resident; monitor vital signs. For symptomatic and unresponsive residents with hypoglycemia (<70 mg/dl or less than the physician-ordered parameter): (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the [DATE] MAR identified on [DATE] at 6:00 AM Resident #8 ' s blood sugar was documented at 528 mg/dl (normal range is 70 - 100 mg/dl). Review of the progress notes dated [DATE] at 6:40 AM identified Resident #8 ' s blood sugar was 528 mg/dl, the resident was alert and responsive with no signs and symptoms of hyperglycemia and the physician was paged. Review of the progress notes dated [DATE] at 9:11 AM identified the ADNS notified the physician that Resident #8 ' s blood sugar was 528 mg/dl at 6:00 AM. Physician's orders dated [DATE] directed to administer Humalog Pen Insulin, Insulin Lispro (fast acting Insulin) 100 unit/ml, per Sliding Scale before meals; 7:30 AM, 11:30 AM, and 5:00 PM. If blood sugar is less than 80 mg/dl, call the physician. If blood sugar is 200 mg/dl to 249 mg/dl, give 2 units. If blood sugar is 250 mg/dl to 300 mg/dl, give 4 units. If blood sugar is 301 mg/dl to 350 mg/dl, give 6 units. If blood sugar is 351mg/dl to 400 mg/dl, give 8 units. If blood sugar is greater than 400 mg/dl, give 10 units and call the physician. Further, the physician ' s order directed to administer Lantus Solostar U-100 Insulin (long acting Insulin), 100 unit/ml, give 28 units daily at 8:00 PM. Resident responsible for self. Review of the [DATE] MAR failed to reflect that the order dated [DATE] at 9:11 AM for Insulin Sliding Scale coverage 3 times daily, and Insulin 28 units at hour of sleep had not been implemented at that time on [DATE] at 9:11 AM, and Resident #8 was without the benefit of Sliding Scale Insulin coverage for his/her blood sugar of 528 mg/dl at 6:00 AM. Review of the [DATE] MAR identified on [DATE] at 11:30 AM, Resident #8 ' s blood sugar was 489 mg/dl (this is in conflict with the blood sugar reading of high) and the resident received 10 units of Sliding Scale Insulin. Review of the [DATE] MAR identified Sliding Scale Insulin coverage of 10 units was administered on [DATE] at 12:00 PM. (This is in addition to the 10 units Insulin that was given at 11:30 AM). Review of the [DATE] [DATE]/,d+[DATE] at 12:00 PM identified the resident ' s blood sugar was 587 mg/dl. Review of the nurse ' s note dated [DATE] at 12:44 PM identified Resident #8 ' s blood sugar registered high. Subsequently, the APRN was notified and ordered a one-time additional dose of Humalog 10 units. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the [DATE] [DATE]/,d+[DATE] at 2:00 PM identified the resident ' s blood sugar was 487 mg/dl. Interview with MD #1 on [DATE] at 8:47 AM identified he was not aware Resident #8 ' s blood sugar on Sunday [DATE] at 6:00 AM was 559 mg/dl. MD #1 indicated he or the APRN should have been notified when the resident ' blood sugar was elevated. Additionally, MD #1 indicated he was aware of the resident ' s increase blood sugar on Monday [DATE] at 6:00 AM of 528 mg/dl and gave a new order to the ADNS for the Sliding Scale. MD #1 indicated that the sliding scale Insulin should have been administered immediately at the time of the order on [DATE] at 9:11 AM. Interview with LPN #13 on [DATE] at 11:38 AM identified she works on the 7:00 AM - 3:00 PM shift and indicated on [DATE] she received report from LPN #14 that Resident #8 ' s blood sugar was high, and the supervisor/(ADNS) was waiting for the physician to call back. LPN #13 indicated she received report that the ADNS had spoken to the physician and new order for a sliding scale was obtained, starting at 200 mg/dl and additional Insulin at 8:00 PM. LPN #13 indicated she was in the middle of passing out medication when the ADNS gave her the new orders for Insulin and she did not document the orders right away. LPN #13 indicated she was going to check Resident #8 ' s blood sugar at 11:30 AM when she does her rounds for blood sugar checks. LPN #13 indicated around 11:30 AM, RN #1 requested a blood sugar check on Resident #8 and the glucometer reading registered high. LPN #13 indicated she can't remember the details exactly what happened or why she documented that Resident #8 ' s blood sugar was 489 mg/dl at 11:30 AM. LPN #13 identified she administered 10 units of Sliding Scale Insulin coverage and notified the APRN at that time. LPN #13 indicated Resident #8 ' s blood sugar at 12:00 PM was 587 mg/dl and the APRN gave an order to administer an additional 10 units of Insulin coverage and recheck the blood sugar in 2 hours at 2:00 PM. At 2:00 PM Resident #8 ' s blood sugar was 487 mg/dl and was given additional coverage of 6 units of insulin. Interview and review of the clinical record with the ADNS on [DATE] at 12:45 PM identified she was the supervisor on duty on [DATE] from 7:00 PM - 7:00 AM, and the next morning ([DATE]). The ADNS indicated on [DATE] at 6:00 AM she was not notified that Resident #8 ' s blood sugar was 528 mg/dl. The ADNS indicated she ran a report on the computer between 7:00 AM and 8:00 AM and the report indicated Resident #8 ' s blood sugar was 528 mg/dl. The ADNS indicated she called the physician at that time and an assessment of Resident #8 for signs and symptoms of hyperglycemia was completed. The ADNS indicated as she was leaving around 8:30 AM the physician returned the call and was updated on the elevated blood sugar. The ADNS indicated she wrote the new orders on a piece of paper and handed the paper to LPN #13 and gave LPN #13 a quick report. The ADNS indicated she also gave an update to the supervisor on duty. The ADNS indicated she documented her notes at 9:11 AM when she arrived at home. Interview with APRN #1 on [DATE] at 12:57 PM identified he was not aware that Resident #8 ' s blood sugar on [DATE] at 6:00 AM was 559 mg/dl. APRN #1 indicated he did not receive a phone call from RN #2 or LPN #12. Interview with LPN #14 on [DATE] at 10:27 AM identified she has been working at the facility through the agency for approximately one month. LPN #14 indicated on [DATE] Resident #8 ' s blood sugar at 6:00 AM was 528 mg/dl and Resident #8 did not have an order for insulin coverage. LPN #14 identified she notified the ADNS regarding the 6:00 AM blood sugar of 528 mg/dl but she did not notify the responsible party. LPN #14 indicated she was unable to document on Resident #8 because she was not trained or oriented on the computer system that the facility uses. LPN #4 indicated that she has not documented whenever she works at the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #2 on [DATE] at 12:01 PM identified LPN #12 did not report to him that Resident #8 had a blood sugar of 559 on [DATE] at 6:00 AM. RN #2 indicated the expectation of the facility is that the charge nurse is to notify the RN supervisor and the RN supervisor will assess the resident for signs and symptoms of hyperglycemia and notify the MD or APRN. RN #2 indicated the charge nurse is responsible to notify the responsible party with any changes in condition during their shift. Interview with LPN #12 on [DATE] at 9:09 AM identified she is employed through the agency and her first day at the facility was on [DATE]. LPN #12 indicated she worked a double shift on the 3:00 PM - 11:00 PM shift and the 11:00 PM - 7:00 AM shift. LPN #12 indicated she cannot remember the residents on the unit and do not remember if any residents had increase blood sugar level. LPN #12 indicated that she did not notify the supervisor/MD/APRN or the responsible party regarding any increase blood sugar on [DATE] at 6:00 AM. LPN #12 indicated she did not document nurse's notes during her double shift and indicated the facility did not orient or train her on how to use the computer system. LPN #12 indicated she signed off when she administered medications. She indicated the facility said they were going to train her on the computer system, and they never did. LPN #12 indicated she received a phone call from the corporate staff at the facility regarding Resident #8 ' s blood sugar. LPN #12 indicated she told him that she does not know the residents by name. Review of the change of condition policy directed to ensure that changes in resident's conditions are reported to providers and families/emergency contacts in a timely fashion. To ensure that residents' changes of condition are assessed and documented properly. Documentation will be noted in the resident's medical record. 44674 3. Resident #3 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, paranoid schizophrenia, and depression. The physician's order dated [DATE] directed to administer Lorazepam (antianxiety medication) 2mg twice daily at 9:00 AM and 9:00 PM. The quarterly MDS dated [DATE] identified Resident #3 had intact cognition, was independent with bed mobility, required assistance with transfers and personal hygiene, and walked independently. The corresponding care plan identified Resident #3 had a potential for symptoms of depression related to the diagnosis of depression and anxiety. Interventions included to administer medications as ordered and observe for signs and symptoms of anxiety. Review of the Lorazepam controlled drug/receipt/record disposition form identified the last available dose of Lorazepam was administered on [DATE] at 9:00 PM. Review of the [DATE] MAR identified Resident #3 refused the scheduled dose of Lorazepam 2mg on [DATE] at 9:00 AM. Documentation indicated the resident is asleep and does not want to be woken up. The [DATE] MAR identified that LPN #5 administered Lorazepam 2mg on [DATE] at 9:00 PM. The [DATE] MAR identified that LPN #4 administered Lorazepam 2mg on [DATE] at 9:00 AM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] MAR identified that LPN #8 administered Lorazepam 2mg on [DATE] at 9:00 PM. Facility documentation identified Resident #3 ran out of the Lorazepam 2mg on [DATE] at 9:00 PM and the pharmacy delivery sheet identified Resident #3 ' s Lorazepam 2mg was delivered to the facility on [DATE] at 12:50 AM, 2 days later. Review of facility documentation identified that although the [DATE] MAR identified that Resident #3 received Lorazepam 2mg on [DATE] at 9:00 PM and [DATE] at 9:00 PM, the residents supply of Lorazepam was not available between [DATE] at 9:00 PM - [DATE] at 12:50 AM. Additionally, the cubex emergency medication kit documentation failed to reflect that the Lorazepam 2mg had been withdrawn for administration on [DATE] at 9:00 PM or on [DATE] at 9:00 PM. Further, the cubex emergency medication kit documentation identified the [DATE] 9:00 AM dose of Lorazepam 2mg was withdrawn on [DATE] at 2:00 PM, 5 hours late. Interview with the DNS on [DATE] at 4:07 PM identified a medication error report was not completed when Resident #3 missed 2 doses of Lorazepam because he was not aware that Resident #3 had missed 2 doses of Lorazepam on [DATE] at 9:00 PM a [TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #9) reviewed for pressure ulcers, the facility failed to ensure the RN/IP assessed the area on admission and ongoing over the course of 4 weeks, including measurements, description, and reassessment, failed to ensure appropriate physician intervention and treatment changes, subsequently, the wound deteriorated to unstageable pressure ulcer without the knowledge of the IP or physician and was identified upon the residents admission to the hospital. The findings include: Resident #9 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, diabetes, and peripheral vascular disease. The discharge tracking MDS dated [DATE] identified Resident #9 had an unplanned discharged to the hospital, return anticipated. Review of the resident census form identified Resident #9 was readmitted from the hospital to the facility on [DATE], over one month later. Review of the hospital discharge summary dated 3/6/22 at 2:06 PM identified Resident #9 was discharged back to the facility with a pressure injury to the left buttock stage II. The Braden Scale (pressure ulcer risk assessment) dated 3/6/22 at 5:57 PM identified Resident #9's sensory perception was completely limited, he/she was unresponsive to painful stimuli due to diminished level of consciousness or sedation, the resident's skin was constantly moist, he/she was bedfast with very limited mobility and required moderate to maximum assistance with moving. A physician's order dated 3/6/22 directed to complete a weekly skin check on shower day (Monday during the 7:00 AM - 3:00 PM shift) and transfer the resident out of bed via a hoyer to the wheelchair. Further, the orders directed to cleanse the left buttocks wound with normal saline followed by foam dressing daily during the 3:00 PM - 11:00 PM shift. A nurse's note dated 3/6/22 at 6:49 PM identified Resident #9 returned to the facility at 4:06 PM via stretcher. A body audit was performed, and a small abrasion was noted to the left buttock. A dry clean dressing was applied. Review of the 1st floor resident shower schedule dated 3/6/22 identified Resident #9's room number was scheduled for a shower on Friday 3:00 PM - 11:00 PM. (not consistent with physician's order). Review of the resident care card dated 3/7/22 identified Resident #9 showers with the assistance of 2 on Monday during the 7:00 AM - 3:00 PM shift. The care plan dated 3/7/22 identified Resident #9 requires assistance in all ADL's related to severe cognitive impairment and muscle weakness. Interventions included to transfer out of bed with the assistance of 2, bed mobility with the assistance of 2, assistance of 1 with toileting, and turn and reposition every 2 hours and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A readmission nutrition assessment dated [DATE] at 11:42 AM identified Resident #9 had an abrasion to the left buttock. The care plans dated 3/7/22 - 3/17/22 failed to reflect documentation related to skin integrity. A wound physician's note dated 3/8/22 identified Resident #9 was seen in consultation for evaluation of wounds. Coccyx first evaluated on 3/8/22. Consult for Resident #9 with a reported open wound along the coccyx however, no wounds noted on evaluation today. The admission MDS dated [DATE] identified Resident #9 had severely impaired cognition, required total 2-person assistance with bed mobility, transfers, toilet use, and personal hygiene. Additionally, Resident #9 was always incontinent of urine and bowel, was at risk of developing pressure ulcers, had no pressure ulcers, had a pressure reducing device for bed, turning and repositioning program, application of nonsurgical dressings, and applications of ointments/medications. A nurse's note dated 3/24/22 at 10:50 PM identified Resident #9's skin was not intact. Skin condition: Wound condition #1 left buttock. Skin interventions: Pressure reducing device for bed. A nurse's note dated 3/25/22 at 10:23 PM identified Resident #9 skin was not intact. Skin conditions: Wound Left buttock. Skin interventions: Pressure ulcer/injury care. Review of the March 2022 TAR identified upon Resident #9's return 3/6/22, a treatment to the left buttock (cleanse left buttocks wound with normal saline followed by foam dressing daily) had been completed on 3/7/22 through 3/31/22 during the 3:00 PM - 11:00 PM shift. Review of the March 2022 TAR identified upon Resident #9's return 3/6/22, weekly skin checks on shower day (Mondays during the 7:00 AM - 3:00 PM shift). The TAR identified that staff documented that weekly skin checks had been completed on 3/7/22, 3/14/22, 3/21/22, and 3/28/22 during the 7:00 AM - 3:00 PM shift, however, there was no corresponding documentation in the clinical record to indicate what the residents skin looked like, if the area on the buttock was improved or deteriorated, or if skin breakdown existed. Review of the nurse's notes dated 3/6/22 through 4/5/22 identified inconsistencies in documentation. The nurse's notes dated 3/9/22, 3/10/22, 3/14/22, 3/16/22, 3/23/22, 3/25/22, 3/27/22, 3/29/22, 4/2/22 and 4/3/22 identified Resident #9's skin was intact, however, the nurse's notes dated 3/24/22, 3/25/22, and 3/29/22 identified Resident #9's skin was not intact and there was a wound to the left buttock. Documentation failed to reflect a description of the non-intact skin, where the non-intact skin was, or measurements/staging. Review of the April 2022 TAR identified a weekly skin check was performed on 4/4/22 during the 7:00 AM - 3:00 PM shift. Further, the TAR identified a treatment was completed on the left buttock wound, (normal saline followed by foam dressing) daily on 4/1, 4/2, 4/3, and 4/4/22, during the 3:00 PM - 11:00 PM shift. A nurse's note dated 4/5/22 at 1:48 PM identified Resident #9 was alert and responsive, the treatment was done as ordered to the left buttock, total care was provided, and the resident was repositioned. Further, Resident #9 was transported via stretcher at 11:10 AM to an appointment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 4/5/22 at 2:04 PM identified the ADNS received a phone call from the hospital that Resident #9 had been transferred to the hospital from the dialysis center. A nurse's note dated 4/5/22 at 10:19 PM identified Resident #9 was admitted to the hospital. Review of the hospital documentation dated 4/5/22 at 8:00 PM identified pressure injury present on hospital admission. Right medial gluteal and left lateral sacrum unstageable. Left lateral sacrum and right medial gluteal/coccyx cleanse with Dakin's solution (a dilute solution of sodium hypochlorite and other stabilizing ingredients, used as an antiseptic to cleanse wounds to treat or prevent infection). Apply Dakin's soaked gauze to wound bases, cover with foam or ABD twice a day. Interview with LPN #9 on 4/11/22 at 11:17 AM identified she is the regular nurse assigned to Resident #9 on the 7:00 AM - 3:00 PM shift. LPN #9 indicated on admission she heard Resident #9 had an abrasion to the left buttock. LPN #9 indicated she was aware that Resident #9 had an open area on the left buttock because on 4/5/22 the nurse aide reported that the dressing on the left buttock was soiled and that was the first time she viewed Resident #9 ' s left buttock. LPN #9 indicated Resident #9 had an open area and a stage II to the left buttock, she indicated she provided treatment as ordered and the Resident #9 left for dialysis. LPN #9 indicated the treatment is done on the 3:00 PM - 11:00 PM shift. LPN #9 indicated she does not perform a skin check on Resident #9 because the resident ' s shower day is on Fridays on the 3:00 PM - 11:00 PM shift. Interview with LPN #2 on 4/12/22 at 1:25 PM identified she is the Infection Preventionist (IP) and the wound nurse. LPN #2 indicated she does wound rounds with the wound physician every week on Tuesdays. LPN #2 indicated she was not aware that Resident #9 had an open area to the left buttock. LPN #2 indicated she and the wound physician made round on 3/8/22 and Resident #9 had no open areas. LPN #2 indicated the facility staff did not notify her that Resident #9 had an open area. LPN #2 indicated the expectation is when the staff observe any open areas, they are responsible to notify her, and she would assess the resident and add the resident to the wound list for the wound physician to assess on his next visit to the facility. Interview with MD #1 on 4/13/22 at 8:50 AM identified he was not aware Resident #9 had an open area to the left buttock and indicated he had confirmed the re-admission orders for Resident #9. Interview with the APRN on 4/14/22 at 10:48 AM identified he was not aware Resident #9 had an open area to the left buttock. The APRN indicated he does not treat the wounds at the facility because the facility has a wound physician. Interview with MD #3 (wound physician) on 4/18/22 at 12:03 PM identified he was not aware Resident #9 had a wound on the left buttock. MD #3 indicated on 3/8/22 he assessed Resident #9 for wounds to the coccyx and indicated Resident #9 ' s skin was intact and that is what he documented. MD #1 indicated the facility staff did not notify him that Resident #9 had an open area to the left buttock. MD #3 indicated his expectation is that the facility staff should have reported the open area to LPN #2, and she would have added the resident to the wound list. MD #3 indicated he does wound rounds every Tuesday. MD #3 indicated if the facility staff had received an order from the medical physician there is no way he would have known. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #15 on 4/18/22 at 12:22 PM identified he has been working at the facility for approximately 2 months through an agency on the 3:00 PM - 11:00 PM shift. LPN #15 indicated the last time he performed a treatment to Resident #9 ' s left buttock open area, the open area was a stage II. Interview with LPN #16 on 5/3/22 at 1:36 PM identified she was not aware Resident #9 had an open area to the left buttock. LPN #16 indicated regarding the weekly skin assessments on 3/14/22, 3/28/22, and 4/4/22 she did not perform a thorough skin check on Resident #9 because the resident was combative during the assessments. LPN #16 indicated she did the best she could and did not see a dressing or an open area to the resident skin. Interview with the Administrator on 5/3/22 at 3:59 PM identified the facility has no documentation to substantiate skin checks were performed weekly on shower days on Resident #9. The Administrator indicated after the issue with Resident #9 the facility has implemented the weekly skin assessment form. Interview with LPN #9 on 5/4/22 at 10:45 AM identified she does not recall filling out the skin note form on 3/16/22 at 3:45 PM and indicated Resident #9 ' s treatment is done on the 3:00 PM - 11:00 PM shift. LPN #9 indicated the first time she saw Resident #9 left buttock open area was on 4/5/22. Review of the weekly skin checks policy identified skin checks are completed by the nurse on shower days and placed in binders. Review of the skin and wound management policy identified the purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries. The purpose of a structured risk assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. Risk factors that increase a resident's susceptibility to develop or to not heal PU/PIs include but are not limited to: Impaired/decreased mobility and decreased functional ability; The presence of previously healed pressure ulcers/injuries. Exposure of skin to urinary and fecal incontinence; Co-morbid conditions, such as end stage renal disease. Cognitive impairment. The facility failed to thoroughly assess the resident ' s skin over a 4 week period, according to professional standards, including weekly measurements and description of a pressure ulcer, failed to notify the IP and physician when the area developed and deteriorated, and failed to ensure appropriate treatments were implemented. The clinical record failed to reflect any description of the wound on the resident ' s right buttock. Subsequently, the wound deteriorated to unstageable pressure ulcer, without the knowledge of the IP or physician, and was identified upon the resident ' s admission to the hospital.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35682 Based on review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #11) reviewed for leave of absence (LOA), the facility failed to follow their policy related to not allowing independent LOAs, failed to complete and document a LOA risk assessment prior to LOA approval, and failed to identify the resident had not returned from LOA by the expected return time. The findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, alcohol abuse, opioid abuse and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #11 had intact cognition, required limited assistance with all activities of daily living and ate independently. The care plan dated 1/26/22 failed to reflect Resident #11's diagnoses of alcohol and opioid abuse. Review of the care plan in the electronic medical record system, (EMR) which was used at the time of resident's admission (October 2021) and prior to the facility's change to a new EMR, identified the resident had a history of alcohol and opioid abuse. However, after the change to a different EMR, the care plan did not include the resident's history of alcohol and opioid abuse. Additionally, when the resident began having independent LOA's, the care plan was not updated to reflect this change in status. A physician's order dated 3/27/22 directed Resident #11 may go on pass with medications. Review of Resident #11's Leave of Absence Log identified the resident went out on LOA on the following dates and times: a. 3/27/22 at 1:16 PM; destination, store; anticipated time of return: supper; time returned: 3:06 PM. b. 4/1/22 at 9:15 AM; destination: DSS; anticipated time of return: 4-6 PM; time returned: 12:25 PM. c. 4/2/22 at 10:00 AM; destination: Store; anticipated time of return: 2-4 PM; time returned: 1:40 PM. d. 4/4/22 at 10:32 AM; destination: DSS; anticipated time of return: 4-5 PM; time returned: 2:50 PM. e. 4/5/22 at 10:34 AM; destination: Store; anticipated time of return: 2-4 PM; time returned: 2:40 PM. f. 4/7/22 at 10:35 AM; destination: Store; anticipated time of return: 2:30-4 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse ' s note, written by LPN #1, dated 4/7/22 at 3:08 PM identified the resident left the facility LOA at 10:30 AM. A nurse's note, written by LPN #1, dated 4/7/22 at 9:48 PM indicated she reported to the RN supervisor at 8:00 PM that Resident #11 had not returned from his/her LOA. A nurse's note written by the RN supervisor, (RN #2), on 4/7/22 at 10:00 PM identified he was informed by LPN #1 that Resident #11 had not returned from LOA. The note indicated the resident had no emergency contact or personal phone contact number and that resident's BIMS score was 15 and he/she was cognitively intact. RN #2 notified the Social Worker, Administrator, DNS, and also contacted the closest hospital, who had no record of the resident. RN #2 contacted the police department to report that the resident had not returned from LOA at the anticipated time. A nurse's note written by RN #2 on 4/7/22 at 10:49 PM identified a police officer arrived at the facility to gather information about Resident #11 and provide case number. A nurse's note, written by RN #2, on 4/8/22 at 3:15 AM identified he received a call from the police department indicating the resident had arrived at hospital emergency room (ER) at 11:00 PM and was medically cleared. The hospital nurse reported to RN #2 that the resident had arrived to the ER with complaints of back pain, right wrist pain and bilateral foot pain sustained after the resident indicated he/she had been dragged by a passenger of a car for two blocks while reaching into the car for a lighter. Diagnostic tests, including x-rays and CT scans showed no findings and the resident was cleared for discharge back to the facility. Resident #11 returned to the facility on [DATE] at 5:00 AM and was thoroughly assessed by RN #2. Hospital discharge documentation was reviewed by RN #2, who noted resident's urine screen was positive for cocaine, which had not been communicated during hospital report. Resident #11 ' s belongings were searched for contraband with no findings. Review of APRN #1's progress note dated 4/8/22 at 9:25 AM identified Resident #11 was seen for follow-up after the ER visit. Resident #11 was out on LOA 4/7/22, went to ER for being dragged by a car for 2 blocks, ankle run over by car, was evaluated at ER and was found to be positive for cocaine. The APRN identified the resident was sleeping, in no distress, when awoken, and denied pain. The note indicated although the resident denied cocaine use, the ER testing indicated positive result. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 4/27/22 at 11:05 AM identified that he was the RN supervisor on 4/7/22 on the 3:00 PM - 11:00 PM shift and 11:00 PM - 7:00 AM shift. RN #2 identified he usually receives report from the charge nurses when making rounds, who will inform him of any concerns. RN #2 identified he was not aware that Resident #11 was out on LOA until LPN #1 informed him at approximately 8:00 PM that the resident had been expected to return from LOA between 2:30 PM - 4:00 PM. RN #2 identified the resident did not have a phone or anyone listed as contacts in the record so there was no way to contact the resident. RN #2 identified the resident had been out on several LOA's recently and had always returned before expected and with no incident. RN#2 identified he contacted the Administrator, DNS, Social Worker and the police and the closest hospital to see if the resident was there. RN #2 identified the police came to the facility to obtain more information at approximately 10:00 PM. RN #2 indicated he received a call from the police department informing him that the resident had arrived at the hospital ER at 11:00 PM after being injured when dragged by a car while reaching in through the passenger side window. RN #2 identified he received a report from the hospital prior to the resident being sent back to the facility however was not informed of resident ' s positive drug screen for cocaine until reviewing hospital paperwork once resident arrived at the facility. RN #2 identified he fully assessed the resident upon return and completed a search of resident and his belongings which was negative for contraband. Interview with LPN #1 on 4/27/22 at 11:40 AM identified that she was Resident #11's charge nurse on the 7:00 AM - 3:00 PM shift and the 3:00 PM - 11:00 PM shift on 4/7/22. LPN #1 identified that prior to the pandemic, the LOA logs for residents were kept at the nurse's station and residents would fill out the log at the time of departure, documenting where they were going and what time they were expected to return. LPN #1 identified during the pandemic when visitation changed, the LOA book was moved from the units down to reception. The nurse on the floor would call reception to let them know that a resident was on their way down and going out LOA so she could allow resident to exit facility since the doors were kept locked. LPN #1 identified on 4/7/22, although she was aware the resident had gone out LOA in the morning, she could not recall if the resident had informed her when he was expected to return but around 8:00 PM, when she realized resident had not returned, she notified RN #2, the nursing supervisor. LPN #1 identified the resident walked independently, was alert and oriented and responsible for himself. LPN #1 identified that because the LOA log was not on the units, unless you speak with the resident when they are leaving it's difficult to keep track of when they are due to return. LPN #1 identified she was not concerned about the resident because he/she had been out on LOA several times recently and never had any issues. LPN #1 identified the resident had not had any violations regarding smoking or contraband and searches upon return have always been negative. LPN #1 identified RN #2 notified the APRN, Administrator, DNS, Social Worker, police and called the local hospital to see if the resident was there. Interview with the Administrator on 4/27/22 at 2:30 PM identified although there was discussion related to resident's request for LOA, prior to obtaining the physician's order, they were unable to find any documentation to support that a LOA risk assessment was completed for Resident #11. The Administrator identified corporate staff sent an email (4/6/22) with revisions and instructions that they were currently rolling out re LOA. the Administrator identified they have held a meeting with the resident council to inform the residents of the changes, which include needing to have someone with them when they go out LOA. They have also moved the LOA sign out logs for residents back to the units instead of maintaining the log in reception. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/27/22 at 2:45 PM identified that she would have expected LPN #1 to have realized by dinner time (5:00 PM) that the resident had not returned from LOA and to have informed the nursing supervisor. The DNS identified she was aware how busy the nurses were, but resident's LOA still should have been identified before 8:00 PM, 4 hours after the resident was expected to return. The DNS further identified the resident should have had a care plan for LOA privileges, which included the need for a risk assessment, search of belongings upon return and following policy. Interview with MD #4 on 4/28/22 at 1:00 PM identified she was Resident #11's physician. Although MD #4 indicated she gave the order for LOA privileges for Resident #11, she did not recall the details of the discussion. MD #4 identified that generally, LOA privileges were granted to residents who were cognitively intact, responsible for themselves and who were not at risk of harming themselves or others. Review of the Leave of Absence Policy last revised on 3/23/22 identified a therapeutic leave of absence occurs when a resident leaves the nursing facility for an activity that may be considered therapeutic (i.e. visiting with family, trip to the local store, etc.) with a physician's order. It is the policy of the facility to not allow independent LOAs. Residents that are mentally and physically capable may be given a physician' s order for a therapeutic LOA at their request no earlier than fourteen days after admission. LOAs are only granted after medical clearance from the physician, evaluation and clearance by physical therapy and discussion/approval by the interdisciplinary team (IDT). The facility will complete the ADVANCED - LOA RISK ASSESSMENT as an IDT and document the results. Approved residents must notify their charge nurse prior to leaving, sign out on the LOA log on the unit, complete the LOA notification form and provide a copy of the form to the front desk before leaving the building with their responsible party. Residents must return within approximately (2) hours of their anticipated return time or contact the facility to advise the charge nurse of the revised anticipated return time. If the resident/responsible party does not contact the facility, the charge nurse will attempt to contact the resident/responsible party. If the resident cannot be located and he/she does not return by midnight, the LOA becomes unauthorized, the physician will be notified, and the LOA will be considered a discharge against medical advice. Review of the Leave of Absence Log identified for resident, by signing myself out, I agree that I will return at the stated time. I agree to notify the facility if I will be late. I agree to sign-in when I return. Additionally, I will follow all contraband policies and understand that interventions, including suspension of my LOA privilege, may be put in place to protect me and the safety of others should these policies be violated. For the resident and responsible party, I agree that the facility is not responsible for the resident's health, safety or well-being while he/she is away from the facility on leave of absence.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44674 Based on review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #5) reviewed for pain, the facility failed to complete and document pain assessments and pain levels and administer pain medication according to the physician ' s orders. The findings include: Resident #5 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome, poly neuropathy, and pain in the right wrist. The quarterly MDS dated [DATE] identified Resident #5 had intact cognition and experiences pain frequently. The corresponding care plan identified Resident #5 had the potential for alteration in comfort related to chronic pain syndrome, neuropathy and reports of right wrist pain. Interventions included to administer analgesics as ordered and evaluate the effectiveness of pain interventions. The physician's order dated 2/24/22 directed to administer MS Contin (pain medication) 15mg every 8 hours (as part of a 45mg total dose), and MS Continue 30 mg every 8 hours, (as part of the 45 mg total dose). The March 2022 MAR identified that MS Contin 30mg was documented as not available on 3/13/22 at 6:00 AM, 2:00 PM and 10:00 PM, and again on 3/14/22 at 6:00 AM. (for a total of 4 missed doses). The March 2022 MAR identified that MS Contin 15mg was documented as not available on 3/13/22 at 6:00 AM, 2:00 PM and 10:00 PM, and again on 3/14/22 at 6:00 AM. (for a total of 4 missed doses). Review of the nurse ' s note for 3/13/22 failed to reflect that staff had monitored or assessed Resident #5 ' s pain Subsequent to APRN notification, on 3/14/22 at 8:09 AM, Resident #5 was assessed for pain and Oxycodone 20mg was ordered to be administered twice on 3/14/22 until the MS Contin was delivered. Facility documentation identified the MS Contin 30mg was delivered to the facility on [DATE] at 12:16 PM. The clinical record identified that Oxycodone 20mg was administered on 3/14/22 at 2:30 PM and 9:00 PM. The March 2022 MAR identified that MS Contin 30 mg was administered on 3/14/22 at 10:00 PM. (The resident had just received Oxycodone 20mg at 9:00 PM). The March 2022 MAR identified that MS Contin 15mg (part of the 45mg dose) was documented as either on order or not available on 3/15/22 at 6:00 AM, 2:00 PM and 10:00 PM and on 3/16/22 at 6:00 AM, 2:00 PM and 10:00 PM for a total of 7 missed doses. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility documentation identified MS Contin 15mg was delivered on 3/17/22. Interview with the DNS via email on 3/21/22 at 4:33 PM identified Resident #5 ' s clinical record failed to reflect nurse ' s note related to Resident #5 ' s pain on 3/12/22 through 3/13/22 including a pain scale. Subsequent to surveyor inquiry on 3/21/22, the DNS obtained a physician ' s order for pain scale assessment every shift. Interview with APRN #1 on 3/23/22 at 10:00 AM identified that he was notified on 3/14/22 that Resident #5 did not receive his/her MS Contin 45mg (3 doses) on 3/13/22 and (1 dose) on 3/14/22. APRN #1 indicated he ordered Oxycodone 20mg to be given twice on 3/14/22 until the MS Contin was delivered. ARPN #1 assessed Resident #5 on 3/14/22 and there were no complaints of pain. ARPN #1 identified he was not aware that Resident #5 received only MS Contin 30mg (instead of 45mg) from 3/14/22 at 10:00 PM through 3/16/22 at 10:00 PM, (7 doses) because the 15 mg had not been delivered. Interview (via email) with the DNS on 3/25/22 indicated that he spoke with Resident #5 on 3/14/22 at approximately 12:30 PM to discuss his/her pain medication and their availability, obtaining an alternative pain medication until the MS Contin was delivered and that the resident was currently at his baseline pain level and not experiencing any undue effects from not having the MS Contin. Review of the pain management policy directed that pain management interventions shall reflect the sources, type and severity of pain. Assess the resident ' s pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Monitor the resident by performing a basic assessment with enough detail and as needed with standardized assessment tools (approved pain scales) and relevant criteria for measuring pain management. Document the residents reported level op pain with adequate detail in accordance with the pain management program. The facility failed to conduct pain assessments, and administer pain medications according to the physician ' s order for Resident #5 who had a diagnosis of chronic pain syndrome, poly neuropathy, and pain in the right wrist.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #10) reviewed for staffing, the facility failed to ensure sufficient staff to meet resident's needs. The findings include: Resident #10 was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease, acute pulmonary edema, morbid severe obesity due to excess calories, asthma, and sleep apnea. The quarterly MDS dated [DATE] identified Resident #10 had intact cognition and required extensive assistance with personal hygiene. Review of the April 2022 MAR directed to check oxygen saturation every shift. Review of the census daily detail by unit form dated 4/9/22 identified the following staffing. First-floor 2 units, census was 41. Second-floor 2 units, census was 32. Third-floor 2 units, census was 55. Review of the nursing schedule dated 4/9/22 during the 11:00 PM - 7:00 AM for the Third-floor, 2 units, census of 55 shift, identified LPN #17 (2nd day of orientation) as the charge nurse. The schedule reflected another LPN who was scheduled on the 3rd floor had called out. A nurse's note dated 4/10/22 at 3:33 AM identified LPN #17 reported to RN #4 that Resident #10 ' s oxygen saturation went down to 63% - 64% on room air. RN #4 went up to the 3rd floor to assess Resident #10 and observed Resident #10 slouched down in bed sleeping. RN #4 rechecked the resident ' s oxygen saturation which was 62% on room air. Oxygen at 2 liters was applied, and the oxygen saturation slowly increases to 70%. The oxygen was increased to 3 liters and the oxygen saturation increased and fluctuate between 74% - 75%. Lungs sounds identified crackles throughout both lungs, nonproductive cough, and the resident remained afebrile. Resident #10 will be sent to the hospital. Resident #10 was transferred to the hospital at 4:10 AM. Review of the resident census form identified Resident #10 was hospitalized on [DATE]. Interview with LPN #17 on 4/13/22 at 2:45 PM identified he is a brand new nurse and indicated his second day of orientation was on 4/9/22 during the 11:00 PM - 7:00 AM shift. LPN #17 indicated he was told by the Acting DNS that he would be working alone on the Third floor unit, and RN #4 would come and check on him. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Acting DNS on 4/13/22 at 3:55 PM identified the facility had staffing issues on 4/9/22 during the 3:00 PM - 11:00 PM shift and indicated he took the keys and the one of the units on the First floor from LPN #9 at 5:00 PM. The Acting DNS indicated at 9:30 PM, LPN #18, the 2nd floor nurse on both units left and he had to take her keys. The Acting DNS indicated at 10:00 PM one of the nurses on the 3rd floor, LPN #1, left and she gave her keys to LPN #8. The Acting DNS indicated LPN #17 was on his 3rd day of orientation and indicated he was not aware that it was LPN #17 second day of orientation. The Acting DNS indicated the facility had no License Nurse staff and he had to leave the new nurse, LPN #17, alone on the Third floor (to oversee two unit with a total census of 55 residents). The Acting DNS indicated he could not stay on the 11:00 PM - 3:00 PM shift. Interview with LPN #17 on 4/14/22 at 8:24 AM identified he did not make rounds at the beginning of the shift on 4/9/22 at 11:00 PM. LPN #17 indicated around 3:00 AM he checked Resident #10 ' s oxygen saturation as ordered and it was 40% and Resident #10 ' s speech was slurred. LPN #17 indicated he checked the oxygen saturation twice and it was between 40% and 47% and Resident #10 was not on oxygen. LPN #17 indicated he left Resident #10 alone and went to search for RN #4. LPN #17 indicated he found RN #4 on the Second floor and notified her that she needed to come with him immediately because a resident oxygen saturation was low on the Third floor. LPN #17 indicated RN #4 went to the Third floor and assessed Resident #10 and the oxygen saturation was 47% on room air. LPN #17 indicated RN #4 went to go and get the oxygen and he left the room to follow RN #4. LPN #17 indicated RN #4 administered the oxygen at 2 liters to Resident #10. LPN #17 indicated RN #4 directed him to ask one of the nurse aides to stay with Resident #10 while she went to call the physician. LPN #17 indicated RN #4 came back and said the physician ordered the resident to be sent out to the hospital. Interview with RN #4 on 4/14/22 at 9:02 AM identified she worked on 4/9/22 during the 11:00 PM - 7:00 AM shift and arrived at the facility at approximately 11:45 PM. RN #4 indicated the Acting DNS gave her report on the staffing issues and the residents that were sent out to the hospital during the 3:00 PM - 11:00 PM shift. RN #4 indicated the Acting DNS notified her that the nurse on the Third floor was on orientation and the nurse that was supposed to orient LPN #17 called out and that LPN #17 was alone. RN #4 indicated the Acting DNS stated LPN #17 counted the narcotics and has the keys to the Third floor both units and RN #4 had to take the First floor both units. RN #4 indicated around 3:35 AM, LPN #17 found her on the second floor and notified her that 2 residents on the Third floor had low oxygen saturation. RN #4 indicated they checked Resident #12 first and his/her oxygen saturation was 86% on room air. RN #4 indicated Resident #12 started talking and his/her oxygen saturation increased to 95% on room air. RN #4 indicated she and LPN #17 went to Resident #10 and checked his/her oxygen saturation and it was fluctuating between 63% - 64% on room air. RN #4 indicated she then left the room to get the oxygen and LPN #17 had followed her and Resident #10 was left alone. RN #4 indicated she placed the oxygen at 2 liters on Resident #10 and repositioned the resident in the bed. RN #4 indicated Resident #10 ' s oxygen saturation was slowly increasing, and she increased the oxygen to 2.5 liters. RN #4 indicated she then checked the oxygen saturation the result was fluctuating between 71% - 72% with oxygen at 2.5 liters. RN #4 indicated she increased the oxygen to 3 liters and had Resident #10 sit up on the side of the bed and directed Resident #10 to take deep breaths. RN #4 indicated upon assessing Resident #10 ' s lung sound she heard bilateral lung crackles. Oxygen saturation result was 88% with oxygen at 3 liters. RN #4 indicated she then directed LPN #17 to stay with Resident #10 while she went to call the physician. RN #4 indicated Resident #10 left at 4:12 AM. RN #4 indicated when she came in at 11:45 PM she notified the Acting DNS that she was not comfortable with the nurse staffing however, the Acting DNS could not stay. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 on 4/14/22 at 8:55 AM identified he has been employed by the facility for approximately for 2 years. RN #3 indicated he was asked to come in on 4/9/22 at 12:00 PM because the facility had issues with staffing. RN #3 indicated he came in and the schedule was not posted by the time clock. RN # 3 indicated the ADNS was the RN supervisor, who indicated a lot was going on between the residents and staffing issues. RN #3 indicated he reviewed the schedule for the 3:00 PM - 11:00 PM shift and there was a blank space for the nurse on the First floor (no nurse), the nurse scheduled for the Second floor was circled which indicates she called out and the second floor was also without a nurse. RN #3 indicated the ADNS called the Acting DNS about the staffing and the answer was the Second floor can work with one nurse. RN #3 indicated that meant that he would have to take the whole second floor as the charge nurse and supervise the building as well. RN #3 indicated he asked who would be working on the First floor, as there was no nurse scheduled, and the Acting DNS, and the ADNS did not give him a straight answer. RN #3 indicated he spoke to the Acting DNS and the ADNS and was uncomfortable about the nurse staffing and being able to safely work, so he did not punch in and he left the facility. RN #3 indicated he came back on 4/10/22 and worked 7:00 AM - 7:00 PM on the Second floor as the charge nurse and was also the RN supervisor for the building. RN #3 indicated every weekend he works the nurse staffing short and not safe for the residents or staff. Interview with LPN #1 on 4/14/22 at 12:00 PM identified she had worked a double shift on 4/9/22 on the Third-floor unit. She worked 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM but she did not stay till 11:00 PM. LPN #1 indicated she left early, she counted and gave report to LPN #8. LPN #1 indicated when she came to work on 4/10/22 on the 7:00 AM - 3:00 PM shift she observed LPN #17 passing out medication on the Third floor (a new nurse on orientation). LPN #1 indicated she did not receive the medication cart back from LPN #17 until 9:00 AM and that put her behind on her medication pass. LPN #1 indicated that LPN #17 did not give one of the resident's their Methadone and she had to call the APRN and obtain an order for a one-time dose to be given on her shift. Interview with LPN #2 on 4/14/22 at 3:10 PM identified she had been working as the Staff Development Nurse prior to 4/11/22 and indicated she did not provide orientation to the new nurse LPN #17. LPN #2 indicated the facility was not notifying her when there was a new employee. Interview with the Staff Coordinator (the scheduler) on 4/14/22 at 2:35 PM identified LPN #17 must do 3 days of orientation and she had schedule LPN #17 for orientation with another nurse on 4/5/22 and 4/9/22 during the 11:00 PM - 7:00 AM shift. Further, the facility did not have LPN #17 ' s LPN license prior to him going on the floor for orientation. Interview with Regional Director of Human Resources on 4/14/22 at 3:18 PM identified she was aware that LPN #17 was a new nurse and indicated a new employee gets 3 days of orientation. The Regional Director of Human Resources indicated she did not know who did the orientation for LPN #17 and indicated she directed the Staff Coordinator to schedule LPN #17 for 3 days of orientation. The Regional Director of Human Resources also indicated she was not aware that the facility did not have LPN #17 license prior to him going on the floor for orientation and indicated there was no orientation check off list for LPN #17. Interview with RN #5 (President of Clinical Service) on 4/14/22 at 3:31 PM identified she was not aware that LPN #17 was only given 3 days for orientation, that his nursing license was not on file prior to him orienting on the unit and there was not an orientation check off list for LPN #17. RN #5 indicated going forward all new employees will have an orientation check off list. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #17 on 4/13/22 at 2:45 PM identified he is a brand-new nurse. LPN #17 indicated his second day of orientation was on 4/9/22 on the 11:00 PM - 7:00 AM shift. LPN #17 indicated he was told by the Acting DNS that he would be working alone on the Third floor unit due to a nurse call out, and RN #4 (the supervisor) would be overseeing him. LPN #17 indicated the Acting DNS and RN #4 came upstairs, and the Acting DNS told him that RN #4 must take the First-floor unit and he would have to take the Third floor by himself, and RN #4 will come and check on him. LPN #17 indicated he told the Acting DNS that he did not have the experience to take the whole Third floor by himself, that he was still on orientation, this was his second day of orientation. LPN #17 indicated the Acting DNS indicated there was no other nurse, and LPN #17 asked to go home.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37293 Based on review of facility documentation, facility policy, and interviews the facility failed to ensure that nursing staff (license nurse and nurse aides) possessed the competencies and skill sets necessary to provide nurse care in a safe and competent manner, and the facility failed to ensure that licensed nursing staff general orientation/training was completed prior to commencement of work on the unit. The findings include: 1. A reportable event form dated 3/31/22 identified Resident #7 had a blood sugar of 40 mg/dl and the nurse attempted to obtain Glucagon from the Cubex machine, but the container would not open. In an effort to keep Resident #7 awake, the nurse placed ice packs on the resident. Upon arrival to the hospital, Resident #7 was noted to be hypothermic with a temperature of 90.9 F. Interview with LPN #10 on 4/12/22 at 11:18 AM identified she rechecked Resident #7's blood sugar and it was 33 mg/dl, so she put the ice on the resident to keep him/her aroused and alert because the facility did not have any Glucagon IM. Please cross reference F684. 2. Review of the census daily detail by unit form dated 4/9/22 identified the following staffing. First-floor 2 units, census was 41. Second-floor 2 units, census was 32. Third-floor 2 units, census was 55. Review of the nursing schedule dated 4/9/22 during the 11:00 PM - 7:00 AM for the Third-floor, 2 units, census of 55 shift, identified LPN #17 (2nd day of orientation) as the charge nurse. The schedule reflected another LPN who was scheduled on the 3rd floor had called out. Interview with the Staff Coordinator (the scheduler) on 4/14/22 at 2:35 PM identified LPN #17 must do 3 days of orientation and she had schedule LPN #17 for orientation with another nurse on 4/5/22 and 4/9/22 during the 11:00 PM - 7:00 AM shift. Interview with LPN #17 on 4/13/22 at 2:45 PM identified he is a brand-new nurse. LPN #17 indicated his second day of orientation was on 4/9/22 on the 11:00 PM - 7:00 AM shift. LPN #17 indicated he was told by the Acting DNS that he would be working alone on the Third floor unit due to a nurse call out, and RN #4 (the supervisor) would check on him. LPN #17 indicated he told the Acting DNS that he did not have the experience to take the whole Third floor by himself, that this was his second day of orientation. LPN #17 indicated the Acting DNS indicated there was no other nurse. The facility failed to ensure LPN #17, a new LPN, received appropriate orientation and possessed the competencies and skill sets necessary to be charge of the third floor, 55 residents, on 4/9/22. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Interview and review of facility documentation on 4/22/22 at 9:00 AM with LPN #2, (the IP and Staff Development Nurse), failed to reflect that competencies for nurses and nurse aides had been completed. LPN #2 identified when she started in the IP role in January 2022, the facility was in the middle of a COVID-19 outbreak which took up most of her time. LPN #2 identified she was still in the process of learning the role and was not aware at the time that she would be responsible for staff education and competencies, other than infection control related education. LPN #2 identified competencies for nurses would include care of the resident with IV ' s, tube feeding, medication administration, and glucometer use. Competencies for nurse aides would include mechanical lift transfers, hand washing and care of the resident with an IV ' s. Interview with the DNS on 4/22/22 at 9:45AM identified all nurses and nurse aides should complete skill competencies annually. The DNS identified documentation prior to November 2021 has been difficult to find, indicating there needs to be a better system of tracking and ensuring education and competencies are completed timely. Although a policy was requested, none was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44674 Based on review of the clinical record, facility documentation, facility policies and interviews for 4 residents (Residents #3, 4, 5 and 6) reviewed for medication administration, the facility failed ensure each resident had a sufficient supply of his/her prescribed medications to meet their individual needs. Additionally, for 1 of 2 residents (Resident #7) reviewed for diabetic management, the facility failed to have Glucagon (a medication to treat severely low blood sugar), readily available for use in emergent situations. The findings included: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, paranoid schizophrenia, and depression. The physician's order dated 10/11/21 directed to administer Lorazepam (antianxiety medication) 2mg twice daily at 9:00 AM and 9:00 PM. The quarterly MDS dated [DATE] identified Resident #3 had intact cognition, was independent with bed mobility, required assistance with transfers and personal hygiene, and walked independently. The corresponding care plan identified Resident #3 had a potential for symptoms of depression related to the diagnosis of depression and anxiety. Interventions included to administer medications as ordered and observe for signs and symptoms of anxiety. Review of the Lorazepam controlled drug/receipt/record disposition form identified the last available dose of Lorazepam was administered on 3/12/22 at 9:00 PM. Subsequently Resident #3 missed 2 doses of Lorazepam 2mg. Facility documentation identified Resident #3 ran out of the Lorazepam 2mg on 3/12/22 at 9:00 PM and the pharmacy delivery sheet identified Resident #3 ' s Lorazepam 2mg was delivered to the facility on [DATE] at 12:50 AM, 2 days later. Review of facility documentation identified that although the March 2022 MAR identified that Resident #3 received Lorazepam 2mg on 3/13/22 at 9:00 PM and 3/14/22 at 9:00 PM, the residents supply of Lorazepam was not available between 3/12/22 at 9:00 PM - 3/15/22 at 12:50 AM. Additionally, the cubex emergency medication kit documentation failed to reflect that the Lorazepam 2mg had been withdrawn for administration on 3/13/22 at 9:00 PM or on 3/14/22 at 9:00 PM. Further, the cubex emergency medication kit documentation identified the 3/14/22 9:00 AM dose of Lorazepam 2mg was withdrawn on 3/14/22 at 2:00 PM, 5 hours late. Interview with the DNS on 3/24/22 at 11:50 AM identified that if a medication is not available, the nurse is responsible to notify the supervisor and the physician/APRN as an alternative medication may be available or if the physician deems it safe to hold the medication, and the pharmacy should be called to get the medication ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication administration policy directed if a medication is not available, it is the nurse ' s responsibility to try to procure the medication and any missed doses must be reported to the responsible party, Medical Director/APRN, shift supervisor and must be documented in Matrix along with all attempts to obtain the medication. Review of the medication reorder policy directed when a medication has 8 days left in supply the charge nurse is to request a refill utilizing the resupply button located in the electronic medication administration record. If a medication is down to 3 days left in supply, the charge nurse will contact the pharmacy to get an expected delivery date, and if the medication does not arrive and a dose is due, the charge nurse will contact the pharmacy and document the reason for delay in delivery, contact MD/APRN for alternative orders and write a progress note to document follow-up. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. The physician's order dated 11/1/21 directed to administer Lorazepam (antianxiety medication) 0.5mg twice daily at 9:00 AM and 9:00 PM. The quarterly MDS dated [DATE] identified Resident #4 has moderately impaired cognition. The corresponding care plan identified Resident #4 receives antianxiety medication related to anxiety disorder. Interventions included to administer medications as order, observe resident for signs or symptoms of anxiety or restlessness, psychiatry consultation and update the physician with concerns or changes. Review of the Lorazepam controlled drug/receipt/record disposition form identified the last available dose of Lorazepam was administered on 3/13/22 at 9:00 PM. Review of the clinical record identified Resident #4 missed 1 dose of Lorazepam 0.5mg. Facility documentation identified Resident #4 ran out of the Lorazepam 0.5mg on 3/13/22 at 9:00 PM and the pharmacy delivery sheet identified Resident #4 ' s Lorazepam 0.5mg was delivered to the facility on [DATE] at 12:50 AM, 1 day later. Interview with the DNS on 3/24/22 at 11:50 AM identified that if a medication is not available, the nurse is responsible to notify the supervisor and the physician/APRN as an alternative medication may be available or if the physician deems it safe to hold the medication, and the pharmacy should be called to get the medication ordered. Interview with LPN #4 on 3/25/22 at 2:30 PM identified that she believes she did call the pharmacy to get the Lorazepam and other narcotics needed. LPN #4 indicated there were some medications given to her on 3/14/22 for other residents, and she indicated she thought she had Resident #4 ' s or might have missed it and signed the MAR by mistake. LPN #4 could not recall the details as she had called the pharmacy that day for other narcotics she needed. (continued on next page)

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New Haven Center for Nursing & Rehabilitation LLC	181 Clifton Street New Haven, CT 06513

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication administration policy directed if a medication is not available, it is the nurse ' s responsibility to try to procure the medication and any missed doses must be reported to the responsible party, Medical Director/APRN, shift supervisor and must be documented in Matrix along with all attempts to obtain the medication. Review of the medication reorder policy directed when a medication has 8 days left in supply the charge nurse is to request a refill utilizing the resupply button located in the electronic medication administration record. If a medication is down to 3 days left in supply, the charge nurse will contact the pharmacy to get an expected delivery date, and if the medication does not arrive and a dose is due, the charge nurse will contact the pharmacy and document the reason for delay in delivery, contact MD/APRN for alternative orders and write a progress note to document follow-up. 3. Resident #5 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome, poly neuropathy, and pain in the right wrist. The quarterly MDS dated [DATE] identified Resident #5 had intact cognition and experiences pain frequently. The corresponding care plan identified Resident #5 had the potential for alteration in comfort related to chronic pain syndrome, neuropathy and reports of right wrist pain. Interventions included to administer analgesics as ordered and evaluate the effectiveness of pain interventions. The physician's order dated 2/24/22 directed to administer MS Contin (pain medication) 15mg every 8 hours (as part of a 45mg total dose), and MS Continue 30 mg every 8 hours, (as part of the 45 mg total dose). The March 2022 MAR identified that MS Contin 30mg was documented as not available on 3/13/22 at 6:00 AM, 2:00 PM and 10:00 PM, and again on 3/14/22 at 6:00 AM. (for a total of 4 missed doses). Review of the MS Contin 15mg controlled drug/receipt/record disposition form identified the last available dose (3 tabs) was administered on 3/12/22 at 10:00 PM. The March 2022 MAR identified that MS Contin 15mg was documented as not available on 3/13/22 at 6:00 AM, 2:00 PM and 10:00 PM, and again on 3/14/22 at 6:00 AM. (for a total of 4 missed doses). Facility documentation identified the MS Contin 30mg was delivered to the facility on [DATE] at 12:16 PM. The March 2022 MAR identified that MS Contin 15mg (part of the 45mg dose) was documented as either on order or not available on 3/15/22 at 6:00 AM, 2:00 PM and 10:00 PM and on 3/16/22 at 6:00 AM, 2:00 PM and 10:00 PM for a total of 7 missed doses. Facility documentation identified MS Contin 15mg was delivered on 3/17/22. Interview and review of the clinical record with Pharmacy Representative #1 on 3/22/22 at 3:00 PM identified that Resident #5 ' s MS Contin 30mg and MS Contin 15mg were refilled on 2/23/22. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pharmacy Representative #1 identified on 3/2/22 the pharmacy had received a refill request for both the MS Contin 15mg and 30mg. The MS Contin 30mg was rejected because the pharmacy system stated it was a duplicate refill and the pharmacy technician deleted the order for the MS Contin 30mg, and the facility received only the MS Contin 15mg, and were administering 3 (15mg) tablets of the MS Contin 15mg to total the ordered dose of 45mg. Pharmacy Representative #1 indicated that Resident #5 ' s MS Contin 30mg request was received at the pharmacy on 3/14/22 at 8:05 AM and delivered and signed by the facility on 3/14/22 at 12:16 PM. Pharmacy Representative #1 further indicated that on 3/2/22 the pharmacy technician should have called the nursing home for clarification of the MS Contin 30mg order, and not just delete the order from the pharmacy system. Review of the inventory on hand available in the cubex emergency medication kit identified MS Contin is not stocked in the cubex. Interview with the DNS on 3/24/22 at 11:50 AM identified that if a medication is not available, the nurse is responsible to notify the supervisor and the physician/APRN as an alternative medication may be available or if the physician deems it safe to hold the medication, and the pharmacy should be called to get the medication ordered. Review of the medication administration policy directed if a medication is not available, it is the nurse ' s responsibility to try to procure the medication and any missed doses must be reported to the responsible party, Medical Director/APRN, shift supervisor and must be documented in Matrix along with all attempts to obtain the medication. Review of the medication reorder policy directed when a medication has 8 days left in supply the charge nurse is to request a refill utilizing the resupply button located in the electronic medication administration record. If a medication is down to 3 days left in supply, the charge nurse will contact the pharmacy to get an expected delivery date, and if the medication does not arrive and a dose is due, the charge nurse will contact the pharmacy and document the reason for delay in delivery, contact MD/APRN for alternative orders and write a progress note to document follow-up. 4. Resident #6 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder and anxiety. The physician's order dated 11/18/21 directed to administer Alprazolam (antianxiety medication) 2mg three times a day at 6:00 AM, 1:00 PM and 6:00 PM. The quarterly MDS dated [DATE] identified Resident #6 had intact cognition. The corresponding care plan identified Resident #6 received antianxiety medication related to anxiety disorder. Interventions included to administer medications as order, observe for signs or symptoms of anxiety and update the physician with concerns or changes. Review of the Alprazolam 2mg controlled drug/receipt/record disposition form identified the last available dose was administered on 3/14/22 at 6:00 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2022 MAR identified Alprazolam 2mg was not administered on 3/14/22 at 1:00 PM and 6:00 PM because it was not available. Review of the pharmacy delivery sheet identified Resident #6 ' s Alprazolam 2mg was delivered to the facility on [DATE] at 12:50 AM. Interview with the DNS on 3/24/22 at 11:50 AM identified that if a medication is not available, the nurse is responsible to notify the supervisor and the physician/APRN as an alternative medication may be available or if the physician deems it safe to hold the medication, and the pharmacy should be called to get the medication ordered. Review of the medication administration policy directed if a medication is not available, it is the nurse ' s responsibility to try to procure the medication and any missed doses must be reported to the responsible party, Medical Director/APRN, shift supervisor and must be documented in Matrix along with all attempts to obtain the medication. Review of the medication reorders policy directed when a medication has 8 days left in supply the charge nurse is to request a refill utilizing the resupply button located in the electronic medication administration record. If a medication is down to 3 days left in supply, the charge nurse will contact the pharmacy to get an expected delivery date, and if the medication does not arrive and a dose is due, the charge nurse will contact the pharmacy and document the reason for delay in delivery, contact MD/APRN for alternative orders and write a progress note to document follow-up. For 4 residents (Residents #3, 4, 5 and 6) the facility failed to follow the medication reorders policy to ensure each resident had a sufficient supply of his/her prescribed medications to meet their needs. Subsequently, the residents missed doses of their medications. Please cross reference F580, F684 and F697. 5. Resident #7 was admitted to the facility on in September 2021 with diagnosis included Type 1 and Type 2 Diabetes Mellitus. The quarterly MDS assessment dated [DATE] identified Resident #7 had intact cognition and was independent with eating with set up only and received insulin injections. Physician ' s orders for March 2022 directed to administer Admelog U-100 Insulin (a fast-acting mealtime insulin): per sliding scale subcutaneous 3 times a day before meals: 6:30 AM, 11:30 AM, and 4:30 PM. If blood sugar is less than 70, call MD. If blood sugar is 150 to 199 give 2 units. If blood sugar is 200 to 249 give 4 units. If blood sugar is 250 to 299 give 6 units. If blood sugar is 300 to 349 give 8 units. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If blood sugar is 350 to 399 give 10 units. If blood sugar is greater than 400 call MD/APRN. Physician ' s orders for March 2022 directed to administer Lantus U-100 Insulin (long acting Insulin) 34 units, subcutaneous twice a day: 8:00 AM and 8:00 PM. Additionally, the physician ' s orders directed to administer Metformin (anti-diabetic medication) 500 mg twice daily at 9:00 AM, and 5:30 PM. The care plan dated 3/28/22 indicated Resident #7 was at potential nutrition risk related to the diagnosis of Type 2 Diabetes. Interventions included to provide a diet of no-added-salt/no concentrated sweets, monitor blood glucose as ordered and notify the physician if indicated by facility parameters. Review of the March 2022 MAR identified the following; On 3/31/22 at 6:30 AM Resident #7 had a blood sugar of 110 mg/dl (normal range is 70 - 100 mg/dl) and did not require insulin coverage, and at 8:00 AM the resident received 34 units of Lantus Insulin. The March 2022 MAR identified on 3/31/22 at 9:00 AM Resident #7 received Metformin 500mg. The March 2022 MAR identified on 3/31/22 at 11:30 AM Resident #7 had a blood sugar of 194 mg/dl. Resident #7 refused the sliding scale coverage of 2 units. Review of a Cubex (the Cubex System is an automated medication dispensing system) transaction dated 3/31/22 at 12:56 PM, the ADNS attempted to withdrawal Glucagon 1mg IM from the Cubex machine, but the medication was not able to be obtained. A nurse ' s note identified on 3/31/22 at approximately 1:15 PM Resident #7 was in bed, unresponsive with his/her eyes opened. The skin was cool and clammy, and the residents blood sugar level was noted to be 40 mg/dl (normal range is 70 - 100 mg/dl). The nursing supervisor was made aware, sugar was given under the resident ' s tongue, and a subsequent blood sugar level was noted to be lower at 33 mg/dl. A nurse ' s note dated 3/31/22 at 2:15 PM identified the ADNS who was also covering as the RN supervisor, was called to the resident ' s room. The note indicated Resident #7 had low blood sugar (40 mg/dl) around lunch time and was intermittently responsive, sweating with pale skin. One sugar pack was administered under the resident ' s tongue at that time and Resident #7 did swallow. Due to a technical malfunction, the Glucagon in the facility ' s Cubex machine was not able to be accessed. EMS arrived and subsequent to APRN notification, Resident #7 was transferred to the emergency room for an evaluation. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A reportable event form dated 3/31/22 identified Resident #7 had a blood sugar of 40 mg/dl and the nurse attempted to obtain Glucagon from the Cubex machine, but the container would not open. In an effort to keep Resident #7 awake, the nurse placed ice packs on the resident. Upon arrival to the hospital, Resident #7 was noted to be hypothermic with a temperature of 90.9 F. The Administrator was updated, an investigation was immediately initiated including education provided to licensed staff. Glucagon immediately procured from pharmacy for all medication carts, and maintenance was immediately requested for the Cubex machine. Pharmacy representative to come and provide additional insulin education, and all diabetic resident ' s orders were audited, and additional order sets entered as needed. A written statement from the Independent Nurse Consultant (RN #1) dated 3/31/22 identified that at 1:30 PM she overheard the receptionist say 911 is coming. RN #1 indicated upon entering Resident #7 ' s room, the resident was non-responsive and there were 6 nurses standing around the resident ' s bed. LPN #9 reported the residents blood sugar was 34, there was no Glucagon available, and they had given Resident #7 several sugar packets. The residents lunch tray on the bedside table was untouched. RN #1 indicated Resident #7 had a bag of ice on each side of his/her body, LPN #10 was applying ice to the resident ' s chest, and another nurse was giving the resident a sternal rub. RN #1 educated the nurses at that time that ice, and sternal rub are not the appropriate treatment for hypoglycemia. RN #1 indicated EMS arrived at 1:40 PM. At 2:00 PM following Resident #7 ' s departure, RN #1, the Administrator, and the ADNS went to the Cubex machine in the supervisor ' s office. The ADNS indicated the Glucagon IM was in the Cubie (cartridge/drawer). RN #1 and the ADNS attempted 3 times to open the Cubie without success, and the ADNS did not know how to override the Cubex machine. RN #1 indicated at 2:15 PM the pharmacy was called for Glucagon for each of the medication carts The hospital emergency room note dated 3/31/22 at 3:19 PM identified Resident #7 was found unresponsive at approximately 1:00 PM at the nursing home with a blood sugar of 30 mg/dl. The hospital admission note dated 3/31/22 at 5:02 PM identified Resident #7 was admitted for hypothermia and hypoglycemia. Resident #7 was found to be hypoglycemic to 30 mg/dl at the nursing home. Resident was given glucagon and 250 ml of Dextrose 10 fluids intravenously which his/her sugar improved to 80 mg/dl in the emergency room . A written statement from the ADNS dated 3/31/22 identified she was called to see Resident #7 who had low blood sugar and was on/off unresponsive around lunch time. Blood sugar rechecked and was 33 mg/dl. The ADNS indicated she immediately went to the Cubex machine to get Glucagon IM for administration, and although she was able to open the Cubex drawer, she was unable to open dedicated Glucagon bin due to a malfunction. The ADNS indicated continuously attempting to get Glucagon IM from Cubex with no success. A written statement from LPN #9 dated 3/31/22 at 5:00 PM indicated at approximately 1:00 PM Resident #7 was incoherent and his/her eyes were opening and closing. LPN #9 checked the resident ' s blood sugar which was noted to be 40 mg/dl. The staff were having a hard time getting the Glucagon out of the Cubex machine and there was none available on the medication carts. A written statement by LPN #10 dated 3/31/22 at 5:44 PM identified she heard LPN #9 yell to get Glucagon. LPN #10 went to go and get Glucagon, and staff were having a hard time getting it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The summary report dated 4/3/22 identified on 3/31/22 Resident #7 was transferred to the hospital after a period of unresponsiveness at the facility and was admitted with a diagnosis of hypothermia and hypoglycemia. The facility immediately initiated an investigation and established a timeline. During the investigation, it was determined that a malfunction of the Cubie in the Cubex machine prevented the ADNS from removing the Glucagon. The Cubie has been replaced and is functioning properly. The facility has also taken the following actions as part of a plan of correction related to this event: Charge nurse was provided with individual counseling, discipline, and education about the appropriate management of residents with hypoglycemia. Glucagon injectable and glucose tablets immediately ordered from the pharmacy and now available in each medication cart. Inventory of Cubex verified and licensed nurses re-educated on its use. Interview with the ADNS on 4/11/22 at 1:57 PM identified she was the RN supervisor on 3/31/22 on the 7:00 AM - 3:00 PM shift and indicated LPN #9 called her around lunch about Resident #7 ' s blood sugar which was low at 40 mg/dl. The ADNS indicated she went to the supervisor ' s office to the Cubex machine and the drawer opened but the Cubie drawer malfunctioned and would not open to allow access to the IM Glucagon and she was unable to get it. The ADNS indicated she had another nurse attempt to open the Cubex machine, which was unsuccessful, so she directed all the nurses to check their medication carts for Glucagon. The ADNS indicated the facility did not have Glucagon gel or Glucagon IM available in any of the medication carts or in the medication rooms. The ADNS indicated she called the pharmacy account manager and called the pharmacy for STAT Glucagon IM and Glucagon Gel and indicated the pharmacy reported that the Glucagon Gel was on back order so she called another pharmacy. The ADNS indicated when the STAT Glucagon was delivered, she supplied each of the medication carts (6 medication carts) with one Glucagon IM, one Glucagon Gel, and one bottle of Glucagon tablets in a Ziploc bag. Interview with the Acting DNS on 4/11/22 at 4:18 PM indicated he was not in the facility when Resident #7 ' s blood sugar was 40 mg/dl and indicated that he was not aware that the medication carts did not have Glucagon IM. The Acting DNS indicated he came to the facility that evening and the ADNS notified him that the Cubex machine malfunction and she was unable to retrieve the Glucagon IM and the medication carts had no Glucagon IM or Glucagon Gel. The Acting DNS indicated that all the medication carts were supplied with one Glucagon IM, one Glucagon Gel, one bottle of Glucagon tablets and staff were educated on hypoglycemia. Interview with MD #1 on 4/13/22 at 8:44 AM identified he was not aware that the facility did not have Glucagon IM or Glucagon Gel available on each medication carts. MD #1 indicated the expectation is that every medication cart and the medication rooms should have Glucagon IM, and Glucagon Gel for emergencies. Review of the facility blood glucose policy identified the purpose is to determine the amount of glucose (sugar) present in the blood and assist in the management of diabetes. Review of the facility medication administration policy identified to provide a safe and effective medication management framework to help eliminate any harm that could be caused at any level of the medication management process. To ensure that licensed facility staff will adhere to proper safety precautions in the administration of medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing care of the resident with diabetes policy identified diabetes is a disorder in which there is relative or absolute lack of insulin. Among other things, glucose (sugar) from food cannot be taken up by the cells, which results in elevated blood sugar (hyperglycemia) and lack of energy for cellular function. Management of hypoglycemia: For symptomatic (lethargic, drowsy) but responsive (conscious) residents with hypoglycemia (<70 mg/dl or less than the physician-ordered parameter): If he/she is unable to swallow: 1) Immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon, or IV 50% dextrose, per facility protocol; 2) Recheck blood glucose in 15 minutes; and 3) Repeat protocol if indicated and recheck blood glucose in 15 minutes. Remain with the resident; monitor vital signs. For symptomatic and unresponsive residents with hypoglycemia (<70 mg/dl or less than the physician-ordered parameter): Immediately administer oral glucose paste to the buccal mucosa, intramuscular glucagon, or IV 50% dextrose, per facility protocol and notify the physician for further orders; If resident remains unresponsive, call 911 (in accordance with resident ' s advance directives). Documentation should reflect the carefully assessed diabetic resident. The facility failed to ensure Glucagon was readily available to licensed staff on the units and in the medication carts for use in an emergency. The investigation found that there was one Glucagon IM in the facility, and it was located in a Cubex machine that malfunctioned and would not release the Glucagon. Further, oral glucose was not available.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35682 Based on review of clinical record, facility policy and interview for 3 of 3 residents (Resident #12, 13 and 14) reviewed for physician's visits, the facility failed to ensure physician's progress notes were included in the medical record. The findings include: Review of Resident #12, 13 and 14's paper and electronic clinical records failed to reflect physician progress notes were completed at least every 60 days. Interview with the DNS on 4/22/22 at 10:00 AM identified that MD #1 is the physician for Resident's #12, 13 and 14. The DNS identified she contacted MD #1 regarding the missing physician's progress notes and MD #1 indicated he had completed progress notes on all 3 residents however, forgot to send them to the facility for uploading into resident's record. The DNS was able to print out the missing progress notes, indicating they should have been in the resident's clinical record. Progress notes for all 3 residents were dated 11/21/21, 1/22/22 and 3/17/22 and subsequent to surveyor inquiry were placed in resident record. Review of the facility's Physician Services policy identified Physician visits and progress notes shall be maintained in accordance with current OBRA regulations and facility policy.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 35682 Based on facility documentation and interview related to mandatory submission of staffing information, the facility failed to ensure complete and accurate direct care staffing information based on payroll data was submitted to CMS per regulation. The findings include: Interview with the Administrator on 4/22/22 at 11:30 AM identified he could not find evidence that the mandatory staffing information had been completed and submitted since the facility's change of ownership in November 2021. The Administrator identified he started as the administrator at the facility on 2/28/22 and had not completed or submitted the mandatory staffing, however, was informed that the corporate office had applied for a waiver. The Administrator indicated he was unaware of the status of the waiver but did know the submissions were to be completed every 3 months. Review of the facility's staffing policy identified that direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter.