STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295029	A. Building B. Wing	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Pine Care Center	1500 Avenue G Ely, NV 89301

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40847 Based on record review and staff interviews, the facility failed to provide the Centers for Medicare and Medicaid Services (CMS) form 10055 to inform the responsible party for one of three residents (Resident(R) 31) reviewed for beneficiary notices out of a total sample of 15 residents that services were no longer covered by Medicare Findings include: Review of the electronic medical record (EMR) Admission Record revealed R31 was admitted into the facility on [DATE]. Review of R31's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/22/22 revealed a Brief Interview for Mental Status (BIMS) of four out of 15, indicating R31 was severely impaired cognitively. R31 was presented a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form to sign and not the resident's responsible party, with the last covered day of Part A services was 02/25/22. There were no options checked on the form indicating which option would be selected for pay or appealing benefits. Interview on 03/09/23 at 4:27 PM the Business Office Manager (BOM) stated at the time was on a leave of absence and the therapy department was assisting with the SNFABN notices. The BOM confirmed R31 had a low BIMS and had a Power of Attorney (POA) who should have been notified with the SNFABN.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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** 26251 Based on record review, interview and document review, the facility failed to ensure it thoroughly investigated an allegation of neglect and failed to ensure it reported its final findings to the state agency for 1 of 11 residents (Resident #6). Findings include: Resident #6 was admitted on [DATE] with atherosclerotic heart disease, hypertension, and diabetes mellitus type II. Resident #6 was readmitted on [DATE] with metabolic encephalopathy, dehydration, and acute kidney failure. On [DATE], Resident #6 was discovered deceased in bed without ordered oxygen tubing/cannula, which was on the floor. On [DATE], the Administrator initiated an investigation for resident neglect, suspended the assigned certified nurse assistant and self-reported the event to the state agency the same day. On [DATE], the Administrator terminated the certified nurse assistant for failure to provide adequate care by not ensuring 2 hour rounding was completed appropriately, and leaving resident without oxygen on as ordered. There was no directive in the job description or policy describing what constituted 2 hour rounding. On [DATE], the certified nurse assistant documented a statement the resident was observed resting peacefully with the oxygen cannula in place at 4:00 AM. On [DATE], a physician documented a Nevada Provider Order for Life-Sustaining Treatment (POLST). The resident chose to attempt resuscitation at that time. There was no documented evidence of discontinuation or modification of the order. The same information was documented on the resident's face sheet. Nevada Revised Statutes (NRS) 449A.563 : Provider of health care required to comply with valid POLST form; modification by provider; transfer of care of patient; exceptions. 1. Except as otherwise provided in this section and NRS 449A.557, a provider of health care shall comply with a valid Provider Order for Life-Sustaining Treatment form, regardless of whether the provider of health care is employed by a health care facility or other entity affiliated with the physician, physician assistant or advanced practice registered nurse who executed the POLST form. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Except as otherwise provided in subsection 4, a provider of health care who is unwilling or unable to comply with a valid POLST form shall take all reasonable measures to transfer the patient to a physician, physician assistant, advanced practice registered nurse or health care facility so that the POLST form will be followed. On [DATE] in the morning, Resident #6 was discovered deceased in bed. There was no documented evidence or interview evidence an employee witnessed the resident's last breath or how long the resident had been without oxygen. On [DATE] at 6:15 AM, the Medical Director was informed the resident had no pulses and had cold skin. On [DATE] at 8:00 AM, the Medical Director confirmed the resident as obviously deceased with rigor mortis, documenting 6:15 AM as the time of death. On [DATE] at 8:30 AM, the Medical Director indicated in all likelihood the resident was deceased ,d+[DATE] hours already when the Medical Director saw the resident at 8:00 AM on [DATE]. The Medical Director verbalized the death was discussed with the Administrator at the time. The medical record lacked documented evidence emergency medical services were activated and whether cardio-pulmonary resuscitation (CPR) was attempted by staff. On [DATE] in the morning, the current Administrator indicated there was no agreement between the facility and the Medical Director allowing a nurse to pronounce death. As of [DATE], the facility failed to document an interview with the Medical Director who received the death notification phone call at 6:15 AM on [DATE]. The Medical Director's documented time of death was different from an opinion offered via interview. As a result, the oxygen could have come off the resident at any time after the last observance of the resident. The facility failed to identify the resident's POLST was not followed. The facility failed to report the certified nurse assistant to the nursing board, which it should have done if it concluded neglect was committed. The facility lacked documented evidence it sent the state agency a final report including investigative findings. Abuse, Neglect, Exploitation or Misappropriation---Reporting and Investigating policy: 8. The following guidelines are used when conducting interviews: c. Should a person disclose information that may be self-incriminating, that individual is informed of his/her rights to terminate the interview until such time as his/her rights are protected. There was no evidence the Administrator informed the certified nurse assistant of such rights. Follow-Up Report 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. There was no evidence the Administrator provided a five day report. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Reported Incident NV00067887 Complaint NV00067924

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17281 Based on record review, observation, interview, and policy review, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessment for dentition was accurately coded for one of 18 sampled residents (Resident (R) 4). The facility's failure to accurately assess relevant care areas about the resident's status, needs, strengths, and areas of decline had the potential to not plan for and provide necessary care. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered documented, revised 03/09/23 revealed, .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 2l days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . Review of R4's face sheet revealed R4 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus and gastritis (inflammation of the stomach). Review of R4's Nursing Admission Screening/History dated 02/09/23, revealed R4 had upper and lower dentures that were not brought with the resident to the facility. Review of the admission MDS with an Assessment Reference Date (ARD) of 02/16/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitively intact and required supervision of one person for eating. Further review of the MDS revealed no documentation R4 had no natural teeth or tooth fragments (edentulous). Observation and in an interview on 03/06/23 at 12:17 PM, revealed R4 sitting in a wheelchair in the resident's room eating lunch. R4 was observed to be edentulous and without dentures in place. R4 stated did not have dentures because they were left at home. In an interview on 03/08/23 at 11:30 AM, the Director of Nursing (DON) stated was responsible for completing the dentition section of the MDS. The DON stated R4 was edentulous and had upper and lower dentures that were not brought to the facility when the resident was admitted . The DON could not explain why the MDS assessment for dentition was inaccurately coded.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17281 Based on record review, interview, and policy review, the facility failed to ensure a baseline care plan was provided for three of 18 sampled residents (Resident (R) 4, R29, and R232). Specifically, the facility failed to develop for R4 a baseline care plan for pressure ulcers; the facility failed to develop for R29 a baseline care plan for antiplatelet medication and skin conditions; and the facility failed to develop for R232 a baseline care plan for oxygen. This failure had the potential for staff not to receive the necessary instructions needed to provide effective care and meet the needs of the residents. Findings include: Review of the undated facility policy titled, Care Plans-Baseline documented, .A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative. b. Physician orders. c. Dietary orders. d. Therapy services and e. Social Services if applicable .The baseline care plan is used until staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan. The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed . 1. Review of the face sheet revealed R4 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus and pressure ulcers. Review of the admission Skin Observation Tool dated 02/09/23, revealed R4 had an unstageable pressure ulcer on the left outer ankle, left lower leg, and left heel and a rash on the right and left buttock. Review of the Baseline Care Plan dated 02/09/23 revealed, .Initial goals based on admission orders: LTC [long term care] strengthening, Physician orders/Medication: MAR [Medication Administration Record]/TAR [Treatment Administration Record], Dietary Orders: Regular, .Social Services: to assist with psychosocial and emotional support and outside referral services. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission MDS with an Assessment Reference Date (ARD) of 02/16/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitively intact, required extensive assistance of two staff for bed mobility, and was always incontinent of bowel and bladder. The MDS further revealed three unstageable pressure ulcers were present on admission, moisture associated dermatitis skin damage and R4 received pressure ulcer care. The baseline care plan failed to include the presence of pressure ulcers and moisture associated dermatitis and interventions to implement for care. 2. Review of the face sheet revealed R29 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease and status post left lower extremity revascularization. Review of the Physician Orders dated 02/15/23, revealed an order for Clopidogrel Bisulfate (antiplatelet medication that can cause bruising or bleeding) 75 milligrams (mg) in the morning for peripheral vascular disease and Aspirin 81 mg every day. Review of the nurses note dated 02/15/23 documented, .Upon admission it is noted that resident has several areas of concern. The right forearm and hand are deep purple, infiltration noted and IV [intravenous] present. This writer removed IV intact, no bleeding, redness, or pain noted. Resident has bilateral bruising on upper and lower arms. Bruising noted on chest, right hip, and lower legs . Review of the Baseline Care Plan dated 02/15/23 documented, .Initial goals based on admission orders: Increase self-care and ADLs [Activities of Daily Living], Physician orders/medications: None, Dietary orders: Regular texture, .Social Services: Assist with outside appointments and services . The baseline care plan failed to include R29's skin condition or the use of antiplatelet medication and interventions to implement for care. In an interview on 03/08/23 at 11:30 AM, the Director of Nurses (DON) stated the admission/charge nurse was responsible to develop the baseline care within 48 hours of admission and should include any care area that needs attention before the comprehensive care plan is developed. The DON confirmed R4's baseline care plan did not include the pressure ulcers and moisture associated dermatitis or interventions needed to promote healing and prevent additional pressure ulcers from developing. The DON confirmed R29's baseline care plan did not include the use of antiplatelet medication, or the skin condition identified on admission. The DON stated when new issues arise, the baseline care plan should be revised as necessary until the comprehensive care plan is developed. 40847 3. Review of R232's face sheet revealed an admitted [DATE]. Review of R232's Diagnosis list revealed diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). Review of R32's Care Plan revealed no care plan for the use of supplemental oxygen. R32's Physician's Orders revealed no orders for the supplemental oxygen to include the rate and how often oxygen was to be used by R232. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the baseline care plan dated 03/03/23 for R232 indicated b. Physician orders/medications: (include catheter or any DME equipment) see Medication Administration Record/ Treatment Administration Record (MAR/TAR). Review of the MAR/TAR revealed no orders for the rate of oxygen needed for R232. On 03/09/23 at 2:59 PM, the DON confirmed the baseline care plan was not completed by staff to include R232's oxygen.

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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** 17281 Based on record review, interview, observation, and policy review, the facility failed to develop a comprehensive care plan for use of anticoagulant and antidepressant medications for one of six sampled residents (Resident (R) 17) reviewed for unnecessary medication and failed to implement interventions for two of five sampled residents (R4 and R29) reviewed for nutrition in a total sample of 18 residents. The facility's failure to develop comprehensive care plan to address the resident's medications and failure to implement interventions for nutrition had the potential to result in necessary care not being provided. Findings include: Review of the facility policy, dated 07/01/18, titled Baseline Care Plan and Comprehensive Assessment documented, .The comprehensive care plan will be completed when the Minimum Data Set (MDS) and the Resident Assessment Instrument (RAI) are completed by all disciplines .The plan of care must be based on the resident's comprehensive assessment and must be completed within seven (7) days after the comprehensive assessment is completed . 1. Review of the face sheet revealed R17 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heartbeat that causes the heart to beat rapidly) and depression. Review of the Physician Order dated 09/12/22 revealed an order for Eliquis (anticoagulant medication that can cause increased risk for bleeding), 5 milligram (mg) two times a day for atrial fibrillation and an order dated 09/13/22 for Mirtazapine (antidepressant medication), 15 mg at bedtime for depression and insomnia. Review of the quarterly MDS with an ARD of 12/11/22 revealed a BIMS score of 11 out of 15 which indicated R17 was moderately cognitively impaired and received an antidepressant and anticoagulant in the last seven days of the assessment period. Review of R17's comprehensive Care Plan failed to reveal a care plan for use of the anticoagulant and antidepressant medications. In an interview on 03/08/23 at 11:30 AM, the DON stated the comprehensive care plan was developed with an interdisciplinary team approach. The DON stated is the MDS Coordinator and is responsible for developing the care plan for medication use and ensuring the care plan is complete. The DON confirmed a comprehensive care plan for the anticoagulant and antidepressant medication was not developed. interventions were not implemented in the comprehensive care plan for the use of anticoagulant or antidepressant medications. 2. Review of R4's face sheet revealed R4 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, pressure ulcers, pain, and gastritis (inflammation of the stomach). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Admission Screening/History dated 02/09/23, revealed R4 had upper and lower dentures that were not brought with the resident to the facility. Review of the 02/09/23 Physician Orders revealed an order for CCHO (controlled carbohydrate) diet with regular texture and consistency and may have between meal and bedtime snack within dietary parameters. Review of the admission Registered Dietitian (RD) Nutrition Evaluation Note dated 02/10/23 revealed R4 was at risk for weight loss, weighed 145.6 pounds, and had a body mass index (BMI) of 31.5. The goals included no significant weight change and recommendations to add house supplement with breakfast, multivitamins, Vitamin C, and Zinc. Review of the Physician Orders revealed the dietitian's 02/10/23 recommendations were implemented. Review of the 02/14/23 weight located in the EMR under the Weight/Vitals tab, revealed R4 weighed 145.6 pounds. This was the first weight located in the EMR after admission. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/16/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitively intact, required supervision of one person for eating, had no weight loss and weighed 146 pounds. Review of the Care Plan dated 02/16/23 revealed, R4's nutrition status was altered and at risk related to medical condition, not consuming more than 75% of meals, pressure ulcers, poor skin integrity, and therapeutic diet. Interventions included to offer a substitute or supplement if meal intake was less than 50% and weigh per facility protocol. Review of the Nutrition Amount Eaten form revealed from 02/09/23 through 02/21/23, R4 consumed less than 50% for 18 meals. Review of the 02/21/23 weight located in the EMR under the Weight/Vitals tab, revealed R4 weighed 137.6 pounds, an eight-pound weight loss in one week, for a 5.49% loss in one week. There was no documentation a reweight was conducted until 03/01/23. Review of the 02/21/23 Physician Orders located in the EMR under the Orders tab, revealed an order for CCHO diet soft and bite sized texture, regular consistency, house supplement with all meals, and allow regular breads. Review of the RD's Nutrition Evaluation Note dated 02/22/23 located in the EMR under the Assessment tab, revealed R4 had a 5% significant weight loss in seven days from 02/14/23. Intake was poor to fair, the diet was downgraded to soft, and bite sized due to edentulous, and house supplement was increased to each meal. Review of the Nutrition Amount Eaten form revealed from 02/09/23 through 02/21/23, R4 consumed less than 50% for 18 meals. Review of the 03/01/23 weight located in the EMR under the Weight/Vitals tab revealed R4 weighed 141.8 pounds and 137.4 pounds on 03/07/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's medical record failed to reveal when R4's intake was less than 50%, a substitute or supplement was offered per the care plan, and a reweight was obtained when a 5-pound weight loss was identified on 02/21/23 per facility policy. In an interview on 03/08/23 at 11:30 AM, the Director of Nurses (DON) stated the facility policy is to obtain a weight the day of admission and obtain a reweight within 24 hours if there is a five-pound difference. The DON confirmed R4 was not weighed on admission and a reweight was not obtained when a greater than 5% weight loss was noted on 02/21/23. The DON stated the charge nurse reviews weights and directs the nurse aide to obtain the reweight. The DON also confirmed there was no documentation that when R4 consumed less than 50% of a meal, a substitute or supplement was offered. In an interview on 03/09/23 at 4:10 PM, the RD stated R4 was at high risk for weight loss on admission due to her multiple medical conditions and a house supplement was included at breakfast in the plan of care. The RD stated R4's weights fluctuated, and weight loss was unavoidable based on R4's diagnoses of pressure ulcer, pain, and poor intake. The RD stated that after the diet was downgraded to soft, and bite sized due to edentulous, and house supplement increased, R4's weight continued to fluctuate. 3. Review of the face sheet revealed R29 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and peripheral vascular disease. Review of the Physician Orders dated 02/15/23 revealed orders for Lasix (medication to treat retention of fluid in the body) 40 milligrams one tablet once a day, regular diet, and may have between meal and bedtime snacks within dietary parameters. Review of R29's Nursing Admission Screening/History dated 02/15/23, revealed a weight of 96 pounds and under general appearance: resident appears thin. Review of the weight located in the EMR under the Weight/Vitals tab, revealed a weight of 96.8 pounds on 02/15/23. Review of the RD Nutrition assessment dated [DATE] revealed a weight of 96.8 pounds, BMI 19.5, with a goal weight of 119-144 pounds. Current food/ fluid intake 50-74%, edema present lower leg 2 plus, resident is under weight and at risk for weight loss. Recommendations included to provide Med Plus supplement (calorie dense supplement) 60 milliliters (ml) two times a day. Review of R29's weights located in the EMR under the Weight/Vitals tab, revealed a weight of 88 pounds on 02/21/23, a 10.8-pound (9.9%) weight loss from admission. A weight obtained on 02/24/23 revealed R29 weighed 88.6 pounds. Review of the Physician Orders dated 02/22/23, revealed an order for Med Plus supplement 90 ml three times a day. Review of the admission MDS with an ARD of 02/22/23 revealed a BIMS score of eight of 15 which indicated R29 was moderately cognitively impaired, required supervision for eating, weight of 88 pounds with 5% weight loss and not on a weight loss program. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's Care Plan dated 02/23/23, revealed R29 was at risk for altered nutrition due to medical conditions, use of a diuretic, and consuming less than 75% of meals. Interventions included supplement per physician order, if intake is less than 50% offer substitute or supplement, dietitian review as needed, and weight per center protocol. Review of the Nutrition Amount Eaten form revealed from 02/23/23 through 03/06/23, R29 consumed less than 50% for 14 meals. Review of the EMR failed to reveal when R29's intake was less than 50%, a substitute or supplement was offered per the care plan. Observation on 03/06/23 at 12:35 PM, revealed R29 in the resident's room eating lunch. R29 received two chicken legs, green beans, mashed potatoes, roll and butter, and cake. R29 ate independently and consumed 50% of the meal. In an interview on 03/08/23 at 11:30 AM, the DON stated the Med Plus supplement was not started when recommended by the RD on 02/17/23. The supplement wasn't ordered until 02/22/23 after a significant weight loss was identified. The DON stated the RD sends new dietary recommendations for a resident via an email to the DON and the dietary manager. The DON stated did not receive an email from the dietitian to add Med Plus supplement to R29's physician orders. The DON further confirmed there was no documentation that when R29 consumed less than 50% of a meal, a substitute or supplement was offered by staff. In an interview on 03/08/23 at 2:00 PM, Certified Nurse Aide (CNA) 4 stated the charge nurse is responsible to provide the additional supplement when the resident eats less than 50% of their meal. In an interview on 03/08/23 at 3:10 PM, Licensed Practical Nurse (LPN) 1 stated was unaware of the care plan intervention to provide an additional supplement to the resident if the resident consumed less than 50% of a meal. LPN 1 stated had not provided any substitutes or additional supplements to R4 or R29. In an interview on 03/08/23 at 03:45 PM, LPN 2 stated during the meal service the CNA is responsible for documenting in the EMR the resident's meal consumption. If documentation is less than 50%, the EMR system will send an alert to the Dietary Manager who will follow-up on interventions for the residents. The CNAs can offer the resident a substitute or supplement. LPN 2 stated could not recall R4 or R29 being offered a substitute or supplement when intake was less than 50% at a meal. LPN 2 stated staff do not document in the EMR if a supplement or substitute is offered to residents. In an interview on 03/09/23 at 4:10 PM, the RD stated after an assessment of a resident, the RD would send any recommendations via email to the DON and Dietary Manager for follow up. The RD stated an email with the recommendation for Med Plus supplement for R29 was inadvertently never sent to the facility on [DATE] and the supplement was not started until 02/22/23. The RD stated R29's received a diuretic and weight loss would occur with the loss of body fluid. The RD stated R29's weight loss was unavoidable due to administration of a diuretic.

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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** 16752 Based on observation, interview, and record review, the facility failed to revise the care plan to include physician orders to receive oxygenation saturation (SPO2) (measurement of how much oxygen is in the blood) readings every shift for one resident (Resident (R) 26) out of a sample of 15 residents. Findings include: Observation on 03/06/23 at 12:23 PM revealed R26 in the resident's room sleeping in the wheelchair wearing nasal oxygen (O2) cannula. Review of the resident's electronic medical records (EMR) revealed R26 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) and acute respiratory failure with hypoxia. Review of R26's five-day Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 02/10/23 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R26 had intact cognition. Review of the MDS indicated the resident was receiving oxygen therapy. Review of the Physician Orders dated 03/09/23, revealed an order to have oxygen saturation (SPO2) checked every shift. Review of R 26's Care Plan with a revision date of 12/22/22, revealed the resident was identified for shortness of breath related to acute respiratory failure. Interventions included monitor and document changes in orientation, increase restlessness, anxiety, and air hunger, provide continuous oxygen as ordered. However, the interventions did not include monitoring the resident's oxygen saturation levels according to physician's orders. An interview was conducted on 03/07/23 at 10:01 AM, Licensed Practical Nurse (LPN) 2 revealed R26 received O2 therapy since COVID outbreak in March 2022 and the physician's orders for the oxygen saturation readings should be reflected on the resident's care plan. An interview on 03/08/23 at 3:30 PM, with the Director of Nursing (DON) revealed the DON handles the MDS assessments, care plan developments, and care plan revision/updates. The DON acknowledged R26's care plan was not revised/updated to reflect the physician's orders for the oxygen saturation monitoring.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40847 Based on interview and record review, the facility failed to ensure a written discharge summary form was completed for one of two residents (Resident (R) 30) reviewed for discharge planning out of a total sample of 15 residents. Findings include: Review of R30's face sheet revealed an admitted [DATE] and discharge date of [DATE] for R30. Review of the resident's Care Plan revealed no discharge planning. Review of the EMR revealed no recapitulation summary. Interview on 03/08/23 at 4:05 PM, the Social Service Director (SSD) stated was unaware of what a recapitulation summary was and had not completed one. The SSD stated completes a form that includes where the resident is being discharged to and the medications provided to the resident. Interview on 03/08/23 at 4:11 PM with the SSD and Licensed Practical Nurse (LPN) 2, both stated when a resident is discharged home the pharmacist will supply a 30-day supply of medications and if the medications are a narcotic, the facility staff will get the resident or responsible party (RP) to sign with two staff members and a copy of the sheet is given to the family and to the pharmacist. The staff stated there are no signature sheets for the regular medication. Interview on 03/08/23 at 4:35 PM, LPN2 stated there was no policy for discharge to home. LPN2 stated the discharge information was provided verbally to the resident/resident representative. The transfer/discharge report, any follow-up appointments, and a medication review with a Medication Administration Record (MAR, were sent home with the resident. LPN2 confirmed there was no specific paperwork obtained with a signature on it verifying the information was received by the resident or resident responsible party.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26251 Based on record review, interview and document review, the facility failed to ensure 1 of 11 residents (Resident #6) received cardiopulmonary resuscitation (CPR) and activation of emergency medical services when needed. Findings include: Resident #6 was admitted on [DATE] with atherosclerotic heart disease, hypertension, and diabetes mellitus type II. Resident #6 was readmitted on [DATE] with metabolic encephalopathy, dehydration, and acute kidney failure. On [DATE] at 6:15 AM, Resident #6 was discovered deceased in bed without ordered oxygen tubing/cannula, which was on the floor. There was no documented evidence or interview evidence an employee witnessed the resident's last breath or how long the resident had been without oxygen. On [DATE] at 6:15 AM, the Medical Director was informed the resident had no pulses and had cold skin. On [DATE] at 8:00 AM, the Medical Director confirmed the resident as obviously deceased with rigor mortis, documenting 6:15 AM as the time of death. On [DATE] in the afternoon, a Licensed Practical Nurse verbalized the resident was obviously deceased , but CPR should have been done based on the Nevada Provider Order for Life-Sustaining Treatment (POLST). On [DATE] at 8:30 AM, the Medical Director indicated in all likelihood the resident was deceased ,d+[DATE] hours already when the Medical Director saw the resident at 8:00 AM on [DATE]. The Medical Director verbalized the death was discussed with the Administrator at the time. The medical record lacked documented evidence emergency medical services were activated and whether anyone attempted CPR. On [DATE], a physician documented a POLST. The resident chose to attempt resuscitation at that time. There was no documented evidence of discontinuation or modification of the order. The same information was documented on the resident's face sheet. Nevada Revised Statutes (NRS) 449A.563 : Provider of health care required to comply with valid POLST form; modification by provider; transfer of care of patient; exceptions. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Except as otherwise provided in this section and NRS 449A.557, a provider of health care shall comply with a valid Provider Order for Life-Sustaining Treatment form, regardless of whether the provider of health care is employed by a health care facility or other entity affiliated with the physician, physician assistant or advanced practice registered nurse who executed the POLST form. 3. Except as otherwise provided in subsection 4, a provider of health care who is unwilling or unable to comply with a valid POLST form shall take all reasonable measures to transfer the patient to a physician, physician assistant, advanced practice registered nurse or health care facility so that the POLST form will be followed. Facility Reported Incident NV00067887 Complaint NV00067924

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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** 40417 Based on interviews, record reviews, and facility policy review, the facility failed to timely assess and monitor 1) a resident for changes of condition following a fall and failed to revise a care plan to prevent further falls (Resident (R) 31) and 2) failed to monitor a resident during the use of anticoagulant medication (and R29) for 2 of 15 sampled residents. Findings include: 1. Review of the facility's policy provided by the Administrator titled, Assessing Falls and Their Causes, dated ,d+[DATE], revealed .The purpose of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall Falls are a leading cause of morbidity and mortality among the elderly in nursing homes .found on the floor without a witness to the event, evaluate for possible injuries . Review of R31's undated admission record revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnosis to include dizziness and giddiness, dementia, unsteadiness on feet, multiple fractures of ribs, syncope and collapse, major depressive disorder ([DATE]), and insomnia. The resident was discharged (expired) on [DATE]. R31 complained of rib pain after the resident suffered a suspected unwitnessed fall (found in floor) on [DATE], leading to a diagnosis on [DATE] of multiple rib fractures with a pneumothorax (collapsed lung) at the local hospital. Review of R31's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) with a score of one out of 15 indicating R31 was severely cognitively impaired, had Alzheimer's, dementia, depression, dizziness, syncope and muscle weakness, and unsteadiness on his feet. Review of R31's Progress Notes revealed the following: [DATE] at 6:06 AM .Resident was observed in sitting position on the floor by the bedside table .c/o [complained of] .pain . written by Licensed Practical Nurse (LPN)1. Further review of this progress note revealed no physical assessment was completed after the fall and complaints of pain. [DATE] at 9:47 AM .daily clonidine 0.1 mg patches for increased muscle spasticity .c.o (sic) [complained] recent pain in back .increased muscle spasticity, increase clonidine patches to 0.2 mg a day for 2 weeks . documented by the Medical Director. Documentation lacked mention of the fall on [DATE]. [DATE] at 3:03 PM .Resident with lower right back/rib/abdominal pain earlier this shift at approx. [approximately] 12:30. Resident appeared to be holding lower rib on that side when approached with facial grimacing noted . written by LPN1. Further review of this progress revealed no physical assessment was completed after the complaints of pain. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 5:01 PM .Acetaminophen .Give .as needed for pain right side abdominal/rib pain . written by LPN1. No physical assessment was documented as being completed at the time the Acetaminophen was administered. [DATE] at 5:18 PM .Lidocaine Pain .Patch .was Ineffective . written by LPN1. [DATE] at 3:28 PM .Resident observed on the floor on the side of closet in room . written by LPN1. Further review revealed no change in condition assessment was completed after this fall. [DATE] at 9:21 AM .transported by EMS [Emergency Medical Service] .hypoxia [low oxygen levels] . written by LPN2. [DATE] at 10:45 AM .his frequent falls has been worse since starting clonidine patches .Patient is transferred to the emergency room for acute hypoxia to rule out PE [pulmonary embolism] .will consider decreasing clonidine patches dosage for frequent falls . written by the Medical Director. [DATE] at 12:15 PM .admitted .pneumothorax with multiple fractures . Review of R31's Emergency Department Note, dated [DATE] revealed .Fall yesterday, Low O2 [oxygen] sats [saturations] .Patient sent over from care center long-term .apparently found off the bed .Patient also has palpable pain to the right lateral rib cage at rib 4 - 5 .pneumothorax .multiple right lateral rib fractures .some significantly displaced . Review of R31's Emergency Department Note dated [DATE] revealed .sent by facility .found off bed . palpable pain to the right lateral rib cage ant rib 4 5 .and R31's document provided by the facility titled General Med revealed .hypoxia .sats 83% it is presumed that patient fell yesterday, as mechanism of potential injury concerned were unwitnessed .notable right rib tenderness with absent lung sounds .X-ray confirmed 100 % pneumothorax with tension .multiple right rib fractures . The facility failed to revise R31's care plan interventions following the fall on [DATE] to prevent further falls, and R31 suffered additional falls on [DATE] and [DATE]. R31 expired at the facility on [DATE]. During an interview on [DATE] at 3:50 PM, LPN 2 confirmed had sent R31 to the hospital per physician's order on [DATE], the resident was admitted and diagnosed with multiple rib fractures and pneumothorax. LPN2 confirmed R31 died at the facility on [DATE]. During an interview on [DATE] at 8:00 AM, R31's Family Member (FM) 1 stated R31 had a fall at the facility around [DATE] and was sent to the emergency room and was diagnosed with rib fractures and a collapsed lung on [DATE]. During an interview on [DATE] at 10:08 AM, Certified Nursing Assistant (CNA) 1 stated R31 suffered a fall on [DATE] and complained of pain and pointed to the rib area. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 10:39 AM, LPN1 stated R31 was observed on the floor on [DATE] and complained of pain. LPN 1 stated had not completed a change of condition assessment on [DATE] when R31 fell and complained of rib pain. LPN1 verified per R31's progress note written by LPN1, R31 had pain at 12:30 PM on [DATE] and did not assess the resident for pain, did not notify the resident's physician about complaints of pain or provide interventions for pain management. LPN1 verified on R31's Medication Administration Record (MAR) had documented administering Tylenol for pain at 5:00 PM on [DATE] with a pain rated as a 7 out of 10 and entered a U (unknown) for the pain medication follow up results. LPN1 stated no new interventions were implemented for R31's fall preventions and R31 suffered another unwitnessed fall (found on the floor) on [DATE]. LPN1 verified that no change of condition assessment was completed after the second fall on [DATE]. LPN1 verified R31 was sent out to the emergency roiagnom on [DATE] and diagnosed with multiple rib fractures and pneumothorax. On [DATE] at 12:25 PM the Director of Nursing (DON) confirmed the note was documented on [DATE] at 6:00 AM by LPN 1 and indicated R31 was found on the floor. The DON reviewed the note and stated some things were missing in the documentation including how the resident got on the floor, if the resident had nonskid socks on their feet, and a skin assessment. The DON confirmed R31's blood pressure was low. The DON confirmed the progress note did not indicate if R31 suffered injuries but did mention the resident had complained of pain. The DON stated expected the facility staff to complete a change of condition assessment for the residents with complaints of pain after found on the floor. The DON confirmed R31 complained of rib pain on [DATE] at 12:00 PM according to LPN 1's progress note, and LPN 1 did not document notifying the physician or providing pain interventions including pain medications until 5 PM on [DATE] with an administration of Tylenol. The DON confirmed LPN 1 documented on R31's MAR a pain rating of 7 out of 10 and had entered U for unknown indicating no results were entered for the effectiveness of the Tylenol administration. The DON confirmed R31 was found on the floor again on [DATE]. The DON confirmed R31 was sent to the emergency room for evaluation on [DATE] and was diagnosed with multiple rib fractures and pneumothorax. On [DATE] at 6:25 PM, the Administrator and the Director of Nursing (DON) were notified of an immediate jeopardy (IJ) situation. The Immediate Jeopardy began on [DATE] when the facility failed to timely identify and assess R31's complaints of rib pain after the resident suffered a suspected unwitnessed fall (found on the floor) on [DATE], leading to R31's diagnosis on [DATE] of multiple rib fractures and a pneumothorax at the local hospital. The facility failed to revise R31's care plan interventions to prevent falls and R31 suffered additional falls on [DATE] and [DATE]. The facility provided an acceptable plan for removal of the immediate jeopardy on [DATE] at 5:23 PM which included the following: The facility would take immediate actions beginning on [DATE] in the form of assessment of residents and education of direct care staff to correct noncompliance that caused or is likely to cause serious injury, serious harm, serious impairment, or death to residents. All direct care staff would be educated by [DATE], [DATE] & prior to their return to work. Audits would be performed weekly on Tuesdays for a period of one year, by the DON/designee for Change of Condition, Pain Assessments, Fall management and Care Plans tools. A Qapi plan for falls, pain, change of condition and care plans, would be put in place, to be reviewed at monthly QA committee meetings for the period of one year. The survey team verified all elements of the facility's IJ Removal Plan and removed the IJ on [DATE] at 3:25 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	17281 2. Review of the facility's policy titled, Acute Condition Changes - Clinical Protocol dated [DATE] documented, .The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications . The physician will help identify medications. The physician will help identify medications and medication combinations that are associated with adverse consequences that could cause significant changes in condition . Review of R29's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (PVD) and status post left lower extremity revascularization. Review of the Physician Orders dated [DATE], revealed an order for Clopidogrel Bisulfate (antiplatelet medication that can cause bruising or bleeding) 75 milligrams (mg) in the morning for peripheral vascular disease and Aspirin 81 mg every day. Review of the Nurses Note dated [DATE] documented, .Upon admission it is noted that resident has several areas of concern. The right forearm and hand are deep purple, infiltration noted and IV [intravenous] present. This writer removed IV intact, no bleeding, redness, or pain noted. Resident has bilateral bruising on upper and lower arms. Bruising noted on chest, right hip, and lower legs . Review of the admission MDS with an ARD of [DATE] revealed a BIMS score of 8 of 15 which indicated R29 was moderately cognitively impaired, required limited assistance for personal hygiene and dressing. Review of the Skin Assessment Tool dated [DATE] documented, bruising on collarbones - unknown cause bilateral bruising (old) and forearms. Review of the resident's Care Plan dated [DATE], revealed the resident has peripheral vascular disease with interventions that included to be free from complications related to PVD and education on importance of foot care, proper fitting shoes, wash and dry feet thoroughly, and inspect feet daily. Review of the Skin Assessment Tool dated [DATE], documented, bilateral bruising noted. Review of the EMR revealed no other assessments of R29's bruising. Review of the Nurses Notes dated [DATE] revealed, .Resident with left arm between wrist and elbow completely bruised. Resident states is unaware of what happened. Resident denies pain or discomfort to area. No visible opening or sore {soreness} at this time to cause bruising. Resident is currently on blood thinners. MD/DON/Family aware. Observation on [DATE] at 12:30 PM, [DATE] at 9:30 AM, and [DATE] at 12:00 PM revealed R29's bilateral forearms from the wrist to the elbow were dark purple in color with different shades of bruising. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:30 AM, the DON stated R29 was observed with dark purple colored skin and bruising on the upper and lower arms, chest, right hip, and left lower leg on admission to the facility on [DATE]. The DON stated the bruising was a side effect of the antiplatelet medication and should be monitored every shift to determine whether the condition is improving or deteriorating. The DON stated monitoring the skin for increased bleeding is the facility policy and a standard of care when a resident is receiving an antiplatelet medication and has complications of the therapy. The monitoring would be documented in the nurse progress notes. The DON confirmed R29's EMR did not include monitoring of the bruising per standards of practice. In an interview on [DATE] at 11:52 AM, the Medical Director stated the resident is receiving two antiplatelet medications for PVD and recent revascularization surgery. The bruised and deep, purple-colored areas on the resident's bilateral arms, chest, and legs are from these medications. The Medical Director stated the resident must take these medications and bleeding under the skin can and has occurred. The areas should be monitored for increased bleeding and reported to the physician if there are any changes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17281 Based on record review, observation, interview, and policy review, the facility failed to provide respiratory care per standards of practice for four of six sampled residents (Resident (R) 23, R29, R26, and R232). Specifically, the facility failed to ensure respiratory equipment was stored properly for R23 and R29. The facility failed to obtain an oxygen saturation level for R26 and failed to obtain a physician order for R232's use of oxygen. Failure to provide respiratory care consistent with professional standards of practice had the potential for residents to not receive the necessary respiratory care per physician orders and the comprehensive care plan. Findings include: 1. Review of the face sheet revealed R23 was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease. Review of the Physician Order dated 02/20/23, revealed an order for Ipratropium-Albuterol (a medication used to prevent difficulty breathing, shortness of breath and wheezing) inhalation solution 0.5-2.5 (3) milligram (mg) per 3 milliliter (ml) inhale 1 application orally four times a day for bronchospasm. Observation on 03/06/23 at 12:07 PM, 03/07/23 at 9:40 AM, and 03/08/23 at 2:00 PM revealed a nebulizer mask uncovered on top of the nebulizer machine on the resident's bedside table. 2. Review of the face sheet revealed R29 was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease. Review of the Physician Order dated 03/05/23, revealed an order for Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg per 3 ml, 1 application inhale orally every six hours for shortness of breath. Observation on 03/06/23 at 12:30 PM, 03/07/23 at 9:30 AM, and 03/08/23 at 12:00 PM revealed a nebulizer mouthpiece uncovered looped around the right siderail of the resident's bed. In an interview on 03/08/23 at 3:30 PM, Licensed Practical Nurse (LPN) 1 stated was not aware of any facility policy for the storage of nebulizer masks or mouthpieces and revealed does not cover nebulizer masks or mouthpieces and places the equipment on the resident's bedside table. In an interview on 03/09/23 at 9:15 AM, LPN 2 stated does not know of any facility policy for storage of oxygen and nebulizer equipment. LPN 2 stated has not covered nebulizer equipment since working at the facility. LPN 2 stated places the nebulizer masks and mouth pieces on the bedside table when not being used. In an interview on 03/09/23 at 10:00 AM, the Director of Nurses (DON) stated could not find a facility policy for storage of oxygen or nebulizer equipment. The DON stated would expect nebulizer equipment to be placed in a bag or covered after use. (continued on next page)

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White Pine Care Center	1500 Avenue G Ely, NV 89301

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16752 3. Review of R26's electronic medical records (EMR) revealed the resident was admitted with diagnoses that included congestive heart failure (CHF), chronic obstructive pulmonary disease, and acute respiratory failure with hypoxia. Review of the MDS with an ARD of 02/10/23 revealed a BIMS score of 14 out of 15 indicating R26's cognition was intact. The MDS indicated the resident was receiving oxygen therapy. Review of the resident's Physician Orders revealed R26 was on continuous oxygen (O2) at two liters (l) per nasal cannula (NC). The resident was also to have oxygen saturation (SPO2) (measurement of how much oxygen level in the blood) every shift. A review of the Vitals summary record located in the Weights/Vitals tab revealed from August 2022 to March 2023 the facility failed to obtain the SPO2 readings according to the physician's orders, 39 times. An interview with LPN2 on 03/07/23 at 10:01 AM revealed the resident had received oxygen therapy since the COVID outbreak in March 2022 when the resident had difficulty breathing and became hypoxic (too little oxygen). LPN2 stated R26 should have pulse ox readings twice a day. During an interview on 03/08/23 at 3:30 PM, the DON acknowledged the missing SPO2 readings. 40847 4. Review of the Admission Criteria policy, dated March 2019, revealed 5. prior to or at the time of admission, the resident's attending physician provides the facility with information needed for the immediate care of the resident, including orders covering at least: b. medication orders including (as necessary) a medical condition or problem associated with each medication ; and, c. routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed interdisciplinary care plan. Observation on 03/06/23 at 12:53 PM revealed R232 with oxygen supplementation via nasal cannula at a rate of two liters of oxygen. Review of R232's face sheet revealed an admitted [DATE]. Review of R232's EMR Diagnosis List included a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Further review of the EMR Physician's Orders, revealed no order for the rate and frequency of supplemental administration of oxygen for R232. Interview on 03/07/23 at 12:58 PM, Licensed Practical Nurse (LPN) 2 stated that R232 orders for oxygen should have been placed in the EMR upon admission but were not entered until 03/06/23 at 9:30 PM, three days after admission. LPN2 stated the nursing staff knew how many liters to give R232 because the nurse who completed the admission left a sticky note indicating the resident could get up to four liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/09/23 2:59 PM the DON stated the orders for residents who are new admits should be placed into the electronic health record upon admission within 24 hours.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40847 Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for 8 hours within a 24-hour period on 10/29/22, 11/05/22, and 11/12/22. The facility census was 30. Findings include: Review of the daily staffing form titled, [NAME] Care Pine Center, revealed on 10/29/22, 11/05/22, and 11/12/22 there was not a registered nurse scheduled to work. Review of the payroll [NAME] Pines Care Center - Time > Timesheets, dated 10/29/22, 11/05/22, and 11/12/22 revealed no RN working on those dates. Interview with the DON on 03/09/23 at 2:47 PM confirmed that the above dates had no RN working.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40847 Based on review of the daily nurse staffing forms and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed personnel on daily posted nurse staffing forms dated 10/01/22 through 02/28/23. This failure increased the potential that residents and visitors would not know whether scheduled and/or actual staffing was sufficient. Findings include: Review of the facility's nursing staff posting, dated 10/01/22 through 02/28/23, revealed the scheduled hours for the Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA) were not provided for total hours of care or actual number hours of care. Interview on 03/09/23 at 2:47 PM the Director of Nursing (DON) confirmed the total number of hours of care were missing from the staff posting.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17281 Based on record review and interview, the facility failed to ensure monitoring for an anticoagulant medication (medication that can cause increased risk for bleeding) was conducted for one of six sampled residents (Resident (R) 17) reviewed for unnecessary medication in a total sample of six residents. This failure had the potential to negatively impact the residents' quality of life. Findings include: Review of R17's face sheet revealed R17 was admitted to the facility on [DATE] with diagnosis that included atrial fibrillation (irregular heartbeat that causes the heart to beat rapidly). Review of the Physician Order dated 09/12/22, revealed an order for Eliquis (anticoagulant medication) 5 milligram (mg), two times a day for atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/22 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R17 was moderately cognitively impaired and received an anticoagulant in the last seven days of the assessment period. Review of R17's Care Plan dated 12/12/22, failed to reveal R17 received an anticoagulant medication or interventions for side effect monitoring. Review of the October 2022 through March 2023 Medication Administration Records (MAR) revealed Eliquis was administered every day at 8:00 AM and 8:00 PM. Review of the EMR failed to reveal R17 was being monitored for side effects with the administration of an anticoagulant medication. In an interview on 03/08/23 at 11:30 AM, the Director of Nurses (DON) stated the facility did not have a policy to monitor for side effects when a resident receives an anticoagulant medication. Nursing standard of care is to monitor for bleeding which could be manifested as nosebleed, blood in the stool or urine, ecchymosis (a discoloration of the skin resulting from bleeding underneath) or bruising more easily. The DON stated anticoagulant side effect monitoring documentation would be located in the nurse's notes or the MAR. The DON stated if the charge nurse did not populate the side effect monitoring order in the physician orders section of the EMR, the MAR would not include to monitor for anticoagulant medication side effects. The DON confirmed the physician orders, nurse's notes, and MAR did not include monitoring for side effects related to the use of an anticoagulant medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17281 Based on record review, interview, and policy review, the facility failed to ensure monitoring for an antidepressant medication was conducted for one (Resident (R) 17) and failed to have a stop date for a psychotropic PRN (as needed) medication for one resident (Resident (R) 31) out of six sampled residents reviewed for unnecessary medications out of a total sample of 15 residents. Findings include: Review of facility's policy titled Psychotropic Medications, ,d+[DATE] and provided by the Administrator, revealed .Residents will not receive medications that are not clinically indicated to treat a specific condition . A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior Drugs .considered .psychotropic .Anti-anxiety medications Psychotropic medication management duration .PRN [as needed] orders for psychotropic medications are limited for 14 days . Residents receiving psychotropic medications are monitored for adverse consequences, including: a. anticholinergics effects - flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation and constipation; b. cardiovascular effects - irregular heart rale or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure, orthostatic hypotension; c. metabolic effects - increased cholesterol and triglycerides, poorly controlled or unstable blood sugar, weight gain; d. neurologic effects - agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events; and e. psychosocial effects - inability to perform ADLs or interact with others, withdrawal or decline from usual social patterns, decreased engagement in activities, diminished ability to think or concentrate . Findings include: Review of the undated facility policy titled, Behavior Monitoring, Evaluation and Discontinuation Orders indicated, .It is the policy of this facility to monitor residents related to psychotropic medications, as indicated by physician's orders. Monitoring of specific behavioral manifestations shall be evaluated, on a periodic and as need basis, to determine appropriateness and applicability .Physician orders to monitor specific behavior shall be obtained by the licensed nurse .The licensed nurse shall also document in the licensed progress notes the resident's response to the medication . 1. Review of the R17's face sheet revealed R17 was admitted to the facility on [DATE] with diagnosis that included depression and insomnia. Review of the Physician Order dated [DATE], revealed an order for Mirtazapine (antidepressant medication) 15 milligrams (mg), at bedtime for depression and insomnia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R17 was moderately cognitively impaired and received an antidepressant in the last seven days of the assessment period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [DATE] through [DATE] Medication Administration Records (MAR) revealed Mirtazapine was administered every day at 8:00 PM. Review of the EMR failed to reveal R17 was being monitored for adverse drug reactions (ADR) with the administration of an antidepressant medication. In an interview on [DATE] at 11:30 AM, the Director of Nurses (DON) stated antidepressant medication ADR monitoring could be located in the nurse's notes, on the Behavior Administration Record (BAR) or the Medication Administration Record (MAR). The DON stated if the charge nurse did not add ADR monitoring in the physician order, the BAR or MAR would not include to monitor for ADR. The DON confirmed the physician orders did not include monitoring for antidepressant ADR. The DON also confirmed R17's nurse's notes, BAR, and MAR did not include monitoring for ADR related to the use of an antidepressant medication. 40417 2. Review of R31's undated admission record revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnosis to include dizziness and giddiness, dementia, unsteadiness on feet, multiple fractures of ribs, syncope and collapse, major depressive disorder ([DATE]), insomnia. R31 expired at the facility on [DATE]. Review of R31's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview for Mental Status (BIMS) with a score of one out of 15 indicating R31 was severely cognitively impaired, had Alzheimer's, dementia, depression, dizziness, syncope and muscle weakness, unsteadiness on feet. Review of R31's Physician's Orders dated ,d+[DATE] revealed the following: .Ativan Injection Solution 2 MG/ML (Lorazepam) *Controlled Drug*Inject 2 mg intramuscularly every 8 hours, as needed for Arression (sic), and agitation related to dementia in other diseases classified elsewhere, severe, with agitation dated [DATE] by the Medical Director. A 14-day duration stop date was not included. Review of R31's Comprehensive Care Plan revealed R31 had no focus, goal, or interventions related to Ativan administration. During an interview on [DATE] at 12:25 PM, the Director of Nursing (DON) confirmed the time frame for administering psychotropic medication PRN was two weeks. The DON confirmed R31 was ordered/administered Ativan PRN. The DON confirmed the resident was on Ativan medication from [DATE] to February 2023 and there was no break in the medication, which was over two weeks. The DON confirmed R31's Ativan as needed order should have been administered for a duration of 14 days and then reviewed but was not. DON confirmed R31's Ativan medication was ordered ongoing. The DON confirmed that the Ativan was administered once on [DATE] at 6:22 PM. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:53 AM, the Pharmacy Consultant (PC) confirmed R31 was ordered Ativan IM (as needed order), a psychotropic medication on [DATE] and for a longer duration of 14 days for aggressive behaviors. The PC confirmed R31's Ativan order was discontinued on [DATE]. The PC confirmed the facility did not document discussions or rationale for R31's as needed psychotropic medication and should have. The PC stated Benzo's affect people's central nervous system and increased risks of falls. The PC confirmed R31's Ativan Order as needed IM [intramuscular] was available for the staff to administer to R31 for use longer than 2 weeks without written documentation of reevaluation of the rationale for the medication. During an interview on [DATE] at 11:56 AM the Medical Director (with LPN2 present and survey team) stated R31 was ordered and administered psychotropic medications, including Ativan as needed for a longer than 14 days duration. The Medical Director stated had ordered R31's Ativan order for an undefined duration (more than 14 days) because R31 was being physically aggressive with the facility staff and other residents. The Medical Director stated R31's Ativan was ongoing because it was needed. The Medical Director stated none of R31's psychotropic medications had increased R31's risk of falls.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40417 Based on interviews, record review, and facility policy review, the facility failed to hold the administration of Clonidine (a medication used to lower blood pressure) prescribed by the physician to treat dementia related behaviors in light of low blood pressures and falls in one resident (Resident (R) 31) out of a total of 15 sampled residents. This failure increased the risk of R31 to have additional low blood pressure readings and increased falls. Findings include: Review of the facility's policy titled Medication Therapy, dated 04/07 and provided by the Administrator, revealed .Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risk .All medication orders will be supported by appropriate care processes and practices . Review of the facility's policy titled Adverse Consequences and Medication Errors, dated 04/14 and provided by the Administrator, revealed . The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as .side effects .Adverse consequences shall be reported to the attending physician and pharmacist .An adverse consequence is defined as .event that is due to or associated with a medication may include .side effect A medication error is defined as the .administration of drugs .which is not in accordance with .manufacturer specifications .or accepted professional standards and principles of the professional (s) providing services .failure to follow manufacturer's instructions and/or accepted professional standards .significant medication-related error or adverse consequence, immediate action is taken .to protect the resident's safety and welfare .Significant . resulting in cognitive deterioration or impairment .life threatening . Review of R31's undated admission record revealed R31 was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnosis to include dizziness and giddiness, dementia, unsteadiness on feet, multiple fractures of ribs, syncope and collapse, major depressive disorder (02/28/22), insomnia without a diagnosis of hypertension. Review of R31's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/22, revealed a Brief Interview for Mental Status (BIMS) with a score of 1 out of 15 indicating R31 was severely cognitively impaired, had Alzheimer's, dementia, depression, dizziness, syncope and muscle weakness, unsteadiness on feet, and no diagnosis of hypertension. Review of R31's Gradual Dose Reduction Review, dated 12/27/22, revealed .Diagnosis for psychopharmacologic medication use Alzheimers [sic], dementia with agitation insomnia MDD [Major Depressive Disorder] .Team Recommendation .start clonidine patch 01 mg . signed by the Director of Nursing (DON), the Medical Director, and the Pharmacy Consultant (PC). Review of R31's Physician's Orders, dated 01/2023 revealed the following orders: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Start date of 12/27/22 for one Clonidine Transdermal Patch 0.1mg/24 hours to be applied to the skin once a week on Tuesdays and to remove per schedule for Alzheimer's disease with late onset dementia in other diseases classified elsewhere, severe, with agitation. Further review of this order revealed it was discontinued on 01/10/23. Start date of 01/10/23 at 8:00 AM for two Clonidine Transdermal Patches 0.1mg/24 hours to be applied to the skin once a week on Tuesdays and remove per schedule for Alzheimer's disease with late onset dementia in other diseases classified elsewhere, severe, with agitation. Further review of this order revealed it was discontinued on 01/23/23. Review of the document titled clonidine hydrochloride, 10/09, located on accessdate.fda.gov revealed . indicated in the treatment of hypertension .Adverse effects .drowsiness .dizziness .bradycardia (low heart rate) .orthostatic symptoms (orthostatic hypotension-lightheadedness or dizziness .weakness .fainting . confusion) .Agitation, anxiety, delirium, delusional perception .hallucinations (including visual and auditory . insomnia, mental depression, nervousness, other behavioral changes .restlessness, sleep disorder . Review of R31's Progress Notes revealed the following: 01/09/23 at 6:06 AM .Resident was observed in sitting position on the floor by the bedside table .c/o [complained of] .pain . written by LPN1. Further review of this progress note revealed R31's blood pressure was low at 92/62 at the time of the fall. 01/09/23 at 9:47 AM .daily clonidine 0.1 mg patches for increased muscle spasticity .c. o (sic) [complained] recent pain in back .increased muscle spasticity, increase clonidine patches to 0.2 mg a day for 2 weeks . The increase in dosage was documented by the Medical Director, without mention of the fall that morning or the low blood pressure of 92/62 taken at 8:00 AM on 01/09/23. Review of R31's Medication Administration Record (MAR) and Treatment Administration Record (TAR), revealed Licensed Practical Nurse (LPN) 1 applied the two Clonidine patches as ordered on 01/10/23 at 8:00 AM despite the low blood pressure reading of 92/62 on 01/09/23 and a low diastolic (bottom number) blood pressure of 130/58 at 8:00 AM on 01/10/23. Review of R31's Comprehensive Care Plan revealed no focus, goal, or interventions such as monitoring blood pressures related to clonidine administration. Further review of the Progress Notes revealed R31 had an additional fall on 01/10/23. Further review of the progress note revealed LPN1 documented the vital signs were within normal limits but did not record the actual readings. 01/11/23 at 10:45 AM the Medical Director documented .R31's frequent falls has [sic] been worse since starting clonidine patches .Patient is transferred to the emergency room for acute hypoxia to rule out PE [pulmonary embolism] .will consider decreasing clonidine patches dosage for frequent falls . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R31's psychopharmacologic interdisciplinary medication review dated 01/23/23, revealed . Diagnosis for .medication use dementia .agitation .Medications to be reviewed Clonidine patch .last review . 12/27/22 target behaviors/symptoms .decline behaviors aggressive evidence of adverse effects .X Falls Team Recommendation .DC Clonidine patch . signed by the DON, the Medical Director, and the Pharmacist Consultant (PC). Review of orders revealed the clonidine patches were discontinued on 01/23/23. During an interview on 03/08/23 at 10:39 AM, LPN1 stated R31's doctor ordered clonidine for R31 to help with behaviors. LPN1 confirmed R31's blood pressure was documented on the MAR as 92/62 and it was considered low on 01/09/23. LPN1 stated a normal blood pressure was 120/70. LPN 1 confirmed had administered R31's clonidine patches on 01/10/23 with a documented diastolic pressure below 60. LPN1 stated R31's physician's order did not include blood pressure parameters for holding a dose of clonidine. LPN1 confirmed did not recall reporting R31's low blood pressure to the resident's provider on 01/09/23 or 01/10/23. LPN1 confirmed R31 suffered a fall on 01/09/23 and 01/10/23. LPN1 stated R31's low blood pressure had potential to increase risk of falls. During an interview on 03/08/23 at 12:25 PM, the DON confirmed R31 was found on the floor on 01/09/23 and 01/10/23 by the facility staff. The DON stated R31's clonidine medication administration should have been held by LPN 1, for R31's low blood pressure on 01/09/23 and 01/10/23. During an interview on 03/09/23 at 9:56 AM, the DON stated considered LPN1's administration of R31's clonidine patches with a low blood pressure as a significant medication error. The DON stated had expected LPN 1 to hold R31's clonidine patches on 01/10/23 and report the low blood pressure to the resident's provider. The DON stated the clonidine medication possibly contributed to R31's falls. During an interview on 03/09/23 at 10:53 AM, the Pharmacy Consultant (PC) confirmed the Medical Director ordered Clonidine that began on 12/27/23 to treat R31's dementia with agitation. The PC confirmed R31's clonidine dose was titrated up on 01/10/23 to two patches 0.2 mg and was discontinued on 01/23/23. The PC stated they found no benefit at that time and the decision was made to discontinue its use. The PC stated the nursing staff reported R31 was verbally and physically aggressive towards them. The PC stated clonidine was used to help with reducing R31's aggressive behavior. The PC confirmed clonidine should be held for a resident's heart rate less than 60 or a blood pressure less than 100/60 and reported to the resident's physician. The PC confirmed a low blood pressure could affect R31's dizziness and increase risk of falling. The PC stated expected LPN1 not to apply R31's two clonidine patches on 01/10/22 with a low diastolic blood pressure and the previous day's fall and considered that as a medication administration error. During an interview on 03/09/23 at 11:56 AM, the Medical Director (with LPN2 present and survey team) stated had increased R31's clonidine to two patches on 01/10/23 after R31 had a fall on 01/09/23. The Medical Director stated was aware R31 had suffered a suspected unwitnessed fall on 01/09/23. The Medical Director stated did not include blood pressure or pulse parameters to hold clonidine patches with R31's orders. The Medical Director stated a diastolic pressure lower than 60 with clonidine patch administration could potentially contribute to R31's fall risk.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observations, interview, record review, and review of facility policy, the facility failed to ensure: 1. the correct standard and transmission-based precautions were implemented and followed to prevent spread of infections for one of one resident (Resident (R)232) on isolation precautions, and 2. staff perform proper hand hygiene during meal service for three residents (R11, R18, and R24). The facility failure to adhere to correct isolation procedure and perform proper hand hygiene has the potential to result in the spread of infectious diseases throughout the facility. Findings include: 1. Observation on 03/07/23 at 12:00 PM during meal service on 300 hall revealed R232's room had an isolation cart outside the door. The cart contained yellow isolations gowns, gloves, and head coverings, however there was no signage posted as to the type of isolation. The Health Aide (HA) was observed to use hand sanitizer then donned isolation gown, and head covering. The HA then walked down to the nurses' station wearing the gown and holding gloves in hand to obtain a box of N95 face mask. The HA returned to the isolation cart outside the isolation room and donned her face mask and gloves. The HA removed a Styrofoam lunch tray from the cart and took it into R232's room. After clearing the resident's overbed table and setting up the resident's lunch tray the HA doffed her personal protective equipment (PPE) in the resident's room. The HA left the room without performing hand hygiene and continued to room [ROOM NUMBER]. The HA removed a meal tray from the cart and took it into room [ROOM NUMBER] and set up the meal tray for the resident. The HA exited room [ROOM NUMBER] and utilized the wall hand sanitizer unit. Interview on 03/07/23 at 12:04 PM with the HA revealed R232 was a new admission and was on contact isolation for 10 days isolation as a precautionary measure since the resident was a transfer from the hospital. The HA stated there should be signage on the resident's door identifying the type of isolation and what PPE is required to enter the room. The HA states staff should wear gowns, gloves, head covering, and N95 face mask. The HA was asked if should have donned the PPE before going to the nurse's station for the box face mask, and stated no. The HA was asked about performing hand hygiene in R232's room. The HA acknowledged did not perform hand hygiene until after exiting room [ROOM NUMBER]. During an interview with the Director of Nursing (DON) on 03/08/23 at 10:00 AM the observation (lack of hand hygiene and isolation signage posting) from the previous day was described. The DON stated staff are to perform hand hygiene before entering and after leaving an isolation room. The DON also states the HA should have gathered all PPE before donning and should not have walked up the hall wearing the isolation gown. The DON further stated when residents are placed on isolation precautions there should be signage on the wall next to the resident's room. Observation on 03/08/23 at 11:10 AM revealed an isolation cart and signage for Droplet Precautions with directions for visitors to report to the nurses' station before entering R232's room. The signage stated that staff were to perform hand hygiene before entering and leaving the room; wear mask when entering the room, and dietary may not enter the room. There was no mention of wearing gown, gloves, or head covering. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/08/23 at 11:48 AM, Certified Nursing Assistant (CNA) 4 revealed that R232 was on contact isolation as precautionary measure for the next seven to ten days since the resident was an admission from the hospital. CNA4 stated staff are required to wear gowns, N95 masks, and gloves when entering R232's room. An additional interview with the DON was held on 03/08/23 at 1:00 PM regarding the signage posted which instructed the staff to wear face masks for Droplet Precaution Isolation. The DON stated had posted the only Droplet Precaution signage left by the previous nursing administration. Observation of R232's room on 03/08/23 at 2:40 PM revealed the following yellow and red signage had been posted with the following guidance: Airborne Precautions (in addition to standard precautions) Visitors report to nursing station before entering room. Use airborne precautions as recommended for residents known or suspected to be infected with infectious agent transmitted person to person by the airborne route (i.e., TB, measles, chickenpox disseminated zoster, etc. Resident placement in an airborne infectious isolation room. Monitor air pressure daily with visual indicators (flutters strips). Keep the door closed when not required for entry. Hand hygiene according to standard precautions. PPE staff wear fit-tested N95 or higher-level respirator for respiratory protection when entering the room of the resident when air borne diseases are suspected. An interview with the DON on 03/09/23 at 11:40 AM, while reviewing signage posted at R232's room revealed the DON was not sure which isolation precautions should be posted. The DON stated R232 was not in a pressurized room, in fact the facility did not have any pressurized rooms for air borne isolation, therefore the Airborne Precautions signage was not the appropriate guidance. 40847 Review of the Handwashing and Hygiene policy, dated August 2019, revealed 2. All personnel shall follow the handwashing hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: o. Before and after eating or handling food; p. Before and after assisting a resident with meals . Observation on 03/07/23 at 11:40 AM revealed staff failed to offer hand hygiene to residents prior to meal service. Continued observation of lunch services on 03/07/23 between 11:47 AM - 11:50 AM, observed one of three staff did not use sanitizer between residents. Observed CNA2 had provided R11 with lunch meal and then lifted the trash lid with hand and emptied items in the trash. Continued observation revealed the trash can had a foot pedal to open the lid. Continued observation revealed CNA2 assisted R18 and R24 with tray set up without sanitizing her hands between residents or after touching the lid of the trash can. Interview on 03/07/23 at 11:51 AM, CNA2 stated doesn't have to sanitize hands between residents unless touches the residents and had touched the trash lid with the top of the tray cover and not the hand. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/09/23 at 2:54 PM, the DON stated the staff are to always use the sanitizer in the dispensers before passing trays, during meal tray service, after meal service, between residents, and before/after resident care. The DON stated during COVID, staff would offer residents hand hygiene with sanitizing wipes but no longer do.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on record review, interviews, and review of facility policy, the facility failed to develop an effective antibiotic stewardship program which includes the Infection Control Preventionist, Pharmacy Consultant, and Medical Director. Findings include: Review of the facility document titled Antibiotic Stewardship, with an effective date of 09/20/19, revealed the policy documented: It is the policy of [NAME] Pine Care Center to implement an Antibiotic Stewardship Program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. a. An ASP Team will be established to be accountable for stewardship activities. The ASP Team may consist of: ASP Physician Champion and/or Medical Director, Administrator, Director of Nursing, infection Preventionist (IP), pharmacy consultant, and laboratory representative. As a team they will: i. Review infections and monitor antibiotic usage patterns on a regular basis ii. Obtain and review antibiograms for institutional trends of resistance. iii. Monitor antibiotic resistance patterns (methicillin resistance staphylococcus aureus (MRSA), vancomycin resistant enterococcus (VRE), extended spectrum beta-lactamases (ESBL) and carbapenem-resistant Enterobacter [NAME] (CRE) etc.) and Clostridium difficile infections. iv. Report on number of antibiotics prescribed (e.g., days of therapy) and the number of residents treated each month. v. Include a separate report for the number of residents on antibiotics that did not meet criteria for active infection. An interview was conducted with the Director of Nursing (DON)/Infection Control Preventionist on 03/08/23 at 4:40 PM. The DON stated the facility had only one resident currently on antibiotic therapy. DON stated had recently started tracking and monitoring the infections and the use of antibiotics in the facility. However, was unaware of the facility's policy and the requirements for the Pharmacy Consultant and Medical Director to develop a program to determine the appropriate use of antibiotics. An interview with the Pharmacy Consultant on 03/09/23 at 11:27 AM revealed he has never attended a meeting for an Antibiotic Stewardship Program; nor was aware of the facility's policy regarding Antibiotic Stewardship Program. The Pharmacy Consultant stated had developed an algorithm for the facility's antibiotic use, which had malfunctioned the past few months because the facility's use of antibiotics is so low that the algorithm does not reflect the antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Medical Director on 03/09/23 at 12:44 PM revealed was unaware of the policy regarding the Antibiotic Stewardship Program. The Medical Director stated communicates with the DON and the Pharmacy Consultant regarding medications for the residents. The Medical Director stated the facility's use of antibiotics is so low that there was no need for close monitoring or tracking.