STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325047	A. Building B. Wing	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Oro Center	1005 Lujan Hill Road Las Cruces, NM 88005

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38148 Based on interview and record review, the facility failed to identify the resident's specific clinical-criteria (rules or standards on which a decision or judgment is made to determine medical necessity) for the Secured Memory Care Unit for 1 (R #131) of 2 (R #17 and R #131) residents sampled for elopement (an act or instance of leaving a safe area or safe premises, done by a person with a mental disorder or cognitive impairment) risk, when they failed to assess R #131 for placement in the Secured Memory Care Unit. This deficient practice is likely to result in residents being placed in seclusion involuntarily. The findings are: A. Record review of R #131's face sheet revealed: 1. An admitted [DATE] and was admitted into the 200 Unit (memory care/locked unit), 2. Admission diagnosis: Unspecified Fracture of upper end of left humerus (the long bone in the arm of humans extending from the shoulder to the elbow), Subsequent encounter for fracture with routine healing, Alcohol Dependence Uncomplicated (a condition in which a person continues to drink despite recurrent social, interpersonal, health, or legal problems as a result of their alcohol use), Degeneration (the state of being degenerate) of nervous system due to alcohol, Hypothyroidism Unspecified (a condition in which the production of thyroid hormone by the thyroid gland is diminished), Essential Hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition), Anxiety disorder unspecified (an anxiety or phobia that does not meet the exact criteria for any other anxiety disorder but is significant enough to cause distress and distress to the person), Depression unspecified (symptoms of depression cause significant distress or impairment in social, occupational, or other important areas of functioning), Gastro-Esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting your mouth and stomach) without esophagitis (inflammation of the esophagus: muscular tube that delivers food from your mouth to your stomach.). B. Record review of R #131's care plan dated 02/11/23 revealed: 1. Resident/Patient is at risk for elopement related to Cognitive Loss/Dementia, C. Record review of R #131's Electronic Medical Record (EMR) revealed: 1. No Elopement assessment was found, (continued on next page)

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. No diagnosis of Dementia was found. 3. PROVIDE TO LAW ENFORCEMENT & SEARCH PARTY AT THE TIME OF ELOPEMENT document 1. Resident's: room number, date of birth, nickname, eye color, hair color, height, weight and distinguishing Characteristics, last known address, favorite places; 2. Center name, Address, City, Phone Number; 3. Clothing description, assistive devices, allergies, pertinent medical information and urgent medication. D. Record review of R #131's MDS (Minimum Data Set) Section C- Cognitive Patterns, revealed a BIMS (Brief Interview for Mental Status) score of 10 [range 00 (not measurable) -15 (alert and oriented)]. E. On 02/23/23 at 2:20 PM, during an interview and record review, the Director of the Memory Care Unit (DMCU) stated the PROVIDE TO LAW ENFORCEMENT & SEARCH PARTY AT THE TIME OF ELOPEMENT document was used as an elopement risk assessment but it only covered the resident's demographic information and was not an actual assessment that determined the resident's risk for elopement. It was also confirmed that residents that transferred from the facilities main units have clinical criteria to be placed in the Memory Care.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38148 41755 Based on record review and interview, the facility failed provide a written notice of transfer to the residents and the resident's representative(s) and have the notice include the required information for 3 (R# 65, R #93, and R #285) of 4 (R# 65, R #93, R #134, and R #285) residents sampled for hospitalization s. This deficient practice could likely result in the resident and/or their representative not knowing the reason for the transfer and their rights to advocate and make informed decision regarding their healthcare. The findings are: R #65 A. Record review of R #65's Electronic Medical Record (EMR) revealed: 1) R #65 was transferred to the hospital on 02/21/23 due to abdominal distention (expansion of the abdomen with sensation of increased pressure). 2) No Transfer Notice was found. R #93 B. Record review of R #93's EMR revealed he 1) R #93's was transferred to the hospital on 01/16/23 was transferred to the hospital on 01/24/23 for Infection Pneumonia, Covid + (a respiratory disease caused by SARS-CoV-2,). 2) No Transfer Notice was found. R #285 C. Record review of R #285's EMR revealed: 1) R #285 was transferred to the hospital on 01/16/23 due to altered mental status (term used to indicate an abnormal state of alertness or awareness). 2) No Transfer Notice was found. D. On 02/27/23 at 3:37 PM, during interview the DON confirmed that the facility was not providing a written notice of transfer to residents/representatives. The DON provided a copy of the notice of hospital transfer that is used by the facility to document verbal notice of transfers. E. Record review of the facility document for verbal notice of transfers no date revealed the form did not include: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Effective date of the transfer discharge 2. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 3. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 38148 41755 Based on record review and interview, the facility failed provide a written notice of the bed hold policy at the time of the transfer to the resident and the resident's representative(s) for 3 (R# 65, R #93, and R #285) of 4 (R# 65, R #93, R #134, and R #285) residents sampled for hospitalization s. This deficient practice could likely result in the resident and/or their representative being unaware of the resident being able to return to their previous room or the next available room upon return from the hospital. The findings are: R #65 A. Record review of R #65's Electronic Medical Record (EMR) revealed: 1) R #65 was transferred to the hospital on 02/21/23 due to abdominal distention (expansion of the abdomen with sensation of increased pressure). 2) No bed hold policy Notice was found. R #93 B. Record review of R #93's EMR revealed he 1) R #93's was transferred to the hospital on 01/16/23 was transferred to the hospital on 01/24/23 for Infection Pneumonia, Covid + (a respiratory disease caused by SARS-CoV-2,). 2) No Transfer Notice was found. R #285 C. Record review of R #285's EMR revealed: 1) R #285 was transferred to the hospital on 01/16/23 due to altered mental status (term used to indicate an abnormal state of alertness or awareness). 2) No bed hold policy Notice was found. D. On 02/24/23 at 1:25 PM, during a review and interview, the Business Office Manager (BOM) provided a copy of the Bed hold policy notice and authorization that is used by the facility. The BOM confirmed that she completes the form when she is able to, sometimes the next day but not at the time of the transfer and she does not provide a written copy to the resident or their representative.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34303 Based on record review and interview, the facility failed to develop a comprehensive person-centered care plan for 2 (R #35, and R #54) of 7 (R #4, R # 35, R #54, R #62, R #65, R #94, and R #131) residents reviewed for Comprehensive Care Plans. Failure to develop a resident centered care plan could likely result in staff failing to understand the needs and treatments for residents to achieve their highest level of well-being. The findings are: R #35 A. Record review of R #35's Electronic Medical Record (EMR) revealed diagnosis: 1.Atrial Fibrillation (A-fib/Irregular, often rapid heartbeat that commonly causes poor blood flow). 2. Congestive Heart Failure (CHF/Chronic condition in which the heart doesn't pump blood as well as it should.) B. Record review of R #35's Physician's Orders revealed: 1. Order date: 11/03/22; Warfarin (anticoagulant medication used to treat blood clots and/or to prevent new clots) Give 7.5 mg (dosage strength of medication) by mouth in the afternoon for CHF and AFib. C. Record review of R #35's Care Plan no date, revealed no plan in place for the use of high-risk medication Warfarin or for chronic cardiac conditions of A-fib or CHF. D. On 02/27/23 at 3:37 PM, during an interview, the DON confirmed that R #35's care plan did not include a care plan for Warfarin or for his chronic cardiac conditions. R #54 E. Record review of R #54's Physician's Orders revealed the following: 1) 12/29/2021 L (left) hand splint No directions specified for order. F. Record review of R #54's Care Plan no date, revealed no plan or interventions for her contractures or splint. G. On 02/22/23 at 1:32 PM, during an interview RN #18, confirmed that R #54 had an order for a left hand splint. H. On 02/22/23 at 1:38 PM, during an interview the MDS Coordinator #2, confirmed R #54 did not have the contractures or splint on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41755

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34303 Based on record review and interview, the facility failed to revise the Care Plan for 3 (R #6, R #32, and R #63) of 3 (R #6, R #32, and R #63) residents sampled for Care Plan, when they failed to: 1) Revise R #6's Care Plan to include R #6 being admitted to the hospital for Hemodialysis treatment (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), 2) Revise R #32's Care Plan to include R #32's non-compliance with fluid restrictions, 3) Revise R #63's Care Plan to show he no longer had a Foley catheter (a flexible tube that a clinician passes through the urethra and into the bladder to drain urine). These deficient practices could likely result in staff being unaware of changes in care being provided and residents not receiving the care related to changes in their health status. The findings are: R #6 A. Record review of R #6's Orders dated 11/18/22 revealed: 1. Resident is to be transported via facility van to [Name of local hospital] every Monday, Wednesday, Friday at approximately 0700 (for Dialysis treatment) . B. Record review of R #6's Care plan revised date 02/23/23 revealed the following: 1. [Name of R #6] exhibits or is at risk . for complications related to hemodialysis [Name of Local Dialysis Center] . M (Monday), W (Wednesday), F (Friday) at 0915 (9:15 am) . C. On 02/27/23 at 2:12 pm, during an interview, the DON stated that R #6 is being discharged from the nursing home and admitted to the hospital Monday, Wednesday, and Friday for dialysis treatment. D. On 2/27/23 at 2:19 PM, during an interview, the MDS Coordinator #2 confirmed the care plan was not updated with the correct dialysis provider. R #32 E. Record review of R #32's Orders dated 04/22/21 revealed: 1. Monitor Daily Fluid Restriction Total: 1500 ml (milliliter) . F. Record Review of R #32's care plan revealed the following: 1. [Name of R #32] is at nutritional risk . 1500 ml fluid restriction Date Initiated: 08/01/2019 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. No plan for non-compliance of fluid restriction. G. On 02/20/23 at 3:52 PM, during an interview R #32 stated that he only drinks soda that his family brings for him and he keeps in his room. H. On 02/22/23 at 1:44 PM, during an interview and observation of R #32's room, RN #11 confirmed that there were sodas in R #32's room. RN #11 said that the resident doesn't usually drink sodas. RN #11 was asked how staff monitored R #32 for the soda intake if they are in his room and he said well he just usually doesn't drink it. RN # 11 said that they document fluids given to him during meals. The sodas are not being documented for fluid intake. I. Record review of R #32's ADL sheet dated February 2023, revealed fluid intake was only documented for meals. J. On 2/22/23 at 2:38 PM, during an interview with the DON she confirmed that R #32 non-compliance with fluid restrictions should be care planned for and wasn't. R #63 K. Record review of the Care Plan dated 12/11/22 revealed the following: [Name of R #63] has Foley catheter in place Anchor catheter to leg and avoid pulling . Keep foxy [sic] catheter off the floor Keep the urine catheter bag inside of the privacy/dignity bag at all times . L. Record review of R #63's Physicians Orders revealed no order for Foley Catheter. M. On 02/27/23 at 12:45 PM, during an interview LPN #8 confirmed that R #63 did not have a Foley Catheter anymore. N. On 02/27/23 at 2:21 PM, during an interview the MDS Coordinator #2 confirmed that R #63's was Care Planned for Foley Catheter and that there was no current order for it. She stated that We can update it. 47510

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to provide Restorative Nursing Program (RNP) services (nursing interventions that promote the resident's ability to maintain optimal physical, mental, and psychosocial functioning, generally initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy) for 1 (R #22) of 2 (R 22, and R #54) residents sampled for Activities of Daily Living (ADL; fundamental skills required to independently care for oneself, such as eating, bathing, dressing and toileting). This deficient practice could likely result in residents experiencing a decline in their abilities to dress, walk, eat, and/or contribute to increased weakness and increased risk for falls. The findings are: A. Record review of R #22's Electronic Medical Record (EMR) revealed the following: 1) R #2 was admitted to the facility on [DATE]. 2) R #2's diagnosis Hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side (affecting the right side of the body of a right-handed person) C. Record review of R #22's Care Plan revealed: Focus: .decreased ability to perform ADL(s) .related to Dementia (disorder that significantly impairs the cognitive functions of an individual to the point where normal functioning in society is impossible) . Goal: .will maintain highest capable level of ADL . D. Record Review of R #22's Physical therapy discharge summary revealed: D/C (Discharge) reason: Maximum potential received. Referred to RNP (June 2022) . E. On 02/27/23 at 3:10 PM, during an interview, the Therapy Director stated that the nursing department handles the Restorative Nursing Program. F. On 02/27/23 at 3:10 PM, during an interview, The DON stated there is no one on restorative care, we haven't had anyone on restorative nursing in the 2 years I have been here. The DON confirmed that the PT discharge did refer R #22 to the restorative but states she was not aware of the referral and no order was received to start R #22 on a Restorative Nursing Program.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34303 Based on observation, interview, and record review the facility failed to provide treatment and services for 1 (R #4) of 1 (R #4) residents sampled for skin condition, when they failed to provide treatment for R #4 self-inflected sore from picking and scratching. This deficient practice could likely result in resident worsening condition and possible infection. The findings are: A. On 02/20/23 at 12:03 PM, during an observation of R #4's room and interview, R #4 was observed scratching and picking at a sore on her face. When asked what happened R #4 stated that she had done it to herself from scratching. B. Record review of R #4's Care Plan date 01/12/23 revealed the following: 1. [Name of R #4] is at risk for skin breakdown as evidenced by limited mobility .fragile skin. [Name of R #4] likes to pick in her face. - Assist/encourage [Name of R #4] in repositioning frequently throughout day/night - Monitor skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, - Observe skin condition with ADL (Activities of Daily Living) care daily and report abnormalities - PRN treatment as ordered for skin picking . - Utilize positioning devices as appropriate to prevent pressure over boney prominences - Weekly skin assessment by license nurse - Provide preventative skin care i.e. lotions, barrier creams as ordered - Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanche easily - Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation - Weekly skin check by license nurse. C. Record review of the Physician's Orders no order for lotions or creams to treat R #4's face. D. On 02/22/23 at 8:53 AM, during an interview LPN #7 was asked if there was any treatment for R #4's sore, LPN #7 stated that he believed they were putting cream on it. Upon review of R #4's orders, at that time, LPN #7 confirmed that there was no order for treatment and that he would inform R #4's medical provider for treatment. LPN #7 confirmed that R #4 has had this issue of picking on and off for some time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 02/22/23 at 9:42 AM, during an interview CNA #15 and CNA #16 confirmed that every now and then R #4 will pick at her face. CNA #15 and CNA #16 confirmed that they noticed R #4 picking at her face on 02/20/23.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 34303 Based on observation, interview, and record review the facility failed to ensure residents with limited mobility (a disability that affects a person's gross motor skills) receive appropriate equipment and assistance to maintain mobility for 1 (R #54) of 1 (R #54) sampled for limited range of motion, when they failed to put on R #54's hand splint for her contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). This deficient practice could likely result in resident worsening of their contractures resulting in pain and discomfort. The findings are: A. On 02/21/23 at 10:24 am, during an observation of R #54 in the common area, revealed contracture of the left hand. No splint observed. B. Record review of R #54 Physician's Orders revealed the following: 1) 12/29/2021 L (left) hand splint. C. On 02/22/23 at 1:32 PM, during an interview RN #18 confirmed that R #54 had an order for a left hand splint. RN #18 stated that R #54 does wear it. D. On 02/22/23 at 1:36 PM, during an observation of R #54 and interview with RN #18 and R #54 revealed R #54 did not have her left hand splint on. R #54 stated that it was over on the shelf of her room. E. On 02/22/23 at 3:04 PM, during an observation of R #54 revealed R #54 with her splint on her wrist.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34303 Based on observation, interview, and record review, the facility failed to keep residents free from accident hazards for 7 (R #6, R #30, R #70, R #80, R #109, R #136, and R #137) of 7 (R #6, R #30, R #70, R #80, R #109, R #136, and R #137) residents on the 700 unit who had poor safety awareness due to dementia or low cognition as measured by their Brief Interview for Mental Status (BIMS a test for cognition) score, when they failed to protect residents from unsafe water temperatures. This deficient practice could likely cause a third degree burns for all 7 residents who had access to this hot water. The findings are: A. Record review of a list of residents with a diagnosis of Dementia on the 700 Unit provided by the DON no date revealed R #30, R #70, R #80, and R #136 noted to have a diagnosis of Dementia. B. Record review of a list of residents with BIMS score (A score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment) on the 700 Unit provided by the DON no date revealed the following: 1) R #6 BIMS 12 2) R #30 BIMS 06, 3) R #70 BIMS 04, 4) R #80 BIMS 00, 5) R #109 BIMS 06, 6) R #136 BIMS 06, and 7) R #137 BIMS 08. C. On 02/24/23 at 1:45 PM, during an interview LPN #18 revealed the following: 1. R #6 has poor safety awareness. 2. R #30, R #70, R #80, and R #136 are cognitively impaired and would not understand something that could cause them harm. D. On 02/24/23 at 11:31 AM, during an observation of the 700 unit revealed the following: 1. room [ROOM NUMBER] water from the sink was extremely hot to touch instantly 2. room [ROOM NUMBER] water from the sink was extremely hot to touch instantly (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. room [ROOM NUMBER] water from the sink was extremely hot to touch instantly E. On 2/24/23 at 12:04, during an observation of the 700 unit and interview with the Maintenance Director (MD) revealed the following: 1. room [ROOM NUMBER] water from the sink was 131.7* F. 2. room [ROOM NUMBER] water from the sink was 140* F. 3. Shower room on 700 unit 131.3* F. F. On 02/24/23 at 12:54 PM, during an observation of the 700 unit water heater and interview MD revealed water heater access doors are located outside of the building. The MD confirmed that the facility did not have a way to secure the access door to the water heater. The MD confirmed that they had no key for the access door. The hot water tank thermometer was reading 140* F. The MD stated We don't know who is turning it up. I would never turn it up that high. The MD confirmed that the facility had a problem with another water heater that someone was messing with. The MD confirmed that they had to put a padlock on that water heater access door but had not locked this water heater. The above findings resulted in an Immediate Jeopardy that was called on 02/24/23 at 2:17 PM. A final Plan of Removal was submitted and approved on 02/24/23 at 3:42 PM. Plan of Removal Water heater temperature was immediately adjusted, and temperature of rooms were immediately assessed. Hot water heater was drained, and lines flushed for entire 700 unit. Water was brought back up to temp . System Change: a. Hot water heater room has been secured by a new double lock system. b. Door is going to be checked daily for security and any deficient practice will be corrected immediately. c. Hot water heater room temperature checks will be conducted daily by maintenance person or designee to maintain at regulation of 110 degrees. d. Seven (7) resident rooms down each hall/unit and shower room will have water temperature checked and logged daily by maintenance person or designee. e. Doors on water heater rooms will be checked for security, daily by maintenance person or designee . The facility was verified to have fully implemented this approved plan of removal on 02/27/23 by: 1. Purging (empty) the hot water heater, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Securing the access door to the water heater for the 700 Unit with 2 locks, and 3. Monitoring hot water temperatures and access door being secured. Upon implementation of the Plan of Removal the Immediate Jeopardy was lifted on 02/24/23 and scope and severity was lowered to E. 38148 47510

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47510 Based on observation and interview, the facility failed to ensure appropriate treatment and services for Foley Catheter tubing (soft plastic or rubber tube that is inserted to the bladder to drain the urine and is connected to a collecting bag) care for 4 (R #92, R #31, R #45, and R #111) of 4 (R #92, R #31, R #45, and R #111) randomly observed residents, when they failed to keep R #92's, R #111's, R #31's and R #45's Foley catheter tubing off the floor. This deficient practice could likely result in residents getting infections. The findings are: R #92 A. On 02/22/23 at 11:52 AM, during an observation of R #92 and interview with LPN #11, revealed R #92's catheter tubing was dragging on the floor while being pushed in his wheelchair. LPN #11 confirmed that R #92's Foley tubing was dragging on the floor and shouldn't be. B. On 02/23/23 at 9:53 AM, during an observation of R #92 and interview with CNA #15, revealed R #92's catheter tubing was touching the floor while he was sitting in his wheelchair. CNA #15 confirmed that R #92's Foley tubing was touching the floor and shouldn't be. R #111 C. On 02/22/23 at 2:55 PM, during an observation of R #111 and interview with CNA #14, revealed R #111's catheter tubing was touching the floor while sitting in his wheelchair. CNA #14 confirmed that R #111's Foley tubing was touching the floor and shouldn't be. D. On 02/23/23 at 12:54 PM, during an observation of R #111 and interview with CNA #15, revealed R #111's catheter tubing was touching the floor while he was sitting in his wheelchair. CNA #15 confirmed that R #111's Foley tubing was touching the floor and shouldn't be. R #31 E. On 02/23/23 at 1:21 PM, during an observation of R #31 and interview with DON, revealed R #31's catheter tubing was touching the floor while he was sitting in his wheelchair. DON confirmed that R #31's Foley tubing was touching the floor and shouldn't be. R #45 F. On 02/23/23 at 1:21 PM, during an observation of R #45 and interview with DON, revealed R #45's catheter tubing was touching the floor while he was sitting in his wheelchair. DON confirmed that R #45's Foley tubing was touching the floor and shouldn't be. G. On 02/23/23 at 1:23 PM, during an interview with DON confirmed that the catheter tubing is supposed to be in the bag covered and not on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of the Facility Care of Policy -Catheter: Indwelling Urinary- dated 02/01/23 revealed Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off of the floor .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47510 Based on interview and record review, the facility failed to ensure ongoing communication and collaboration with the dialysis (clinical purification of blood as substitute for normal kidney functioning) center for 1 (R #6) of 1 (R #6) residents reviewed for dialysis, when they failed to have communication with the hospital (facility providing R #6's dialysis). If the facility is unaware of the status, condition or complications that arise during dialysis treatment, then residents are likely to not receive the appropriate monitoring and care they need. The findings are: A. Record review of R #6's Physicians Orders dated 11/18/22 revealed Resident is to be transported via facility van to [Name of local hospital] every Monday, Wednesday, Friday at approximately 0700 (7:00 am) . B. Record review of R #6's Electronic and Paper Medical Record revealed the following: 1. A form from the hospital providing dialysis titled Discharge instructions dated 01/16/23 that had no comments in the communication/collaboration portion was found. 2. No other communication from the hospital regarding R #6's dialysis treatment was found for any date. C. On 02/27/23 at 2:12 pm, during an interview the DON stated that R #6 is being discharged from the nursing home and admitted to the hospital for dialysis treatment and the hospital doesn't provide dialysis communication.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47510 Based on observation and interview, the facility failed to post the Nurse Staffing Information in a prominent place, this could affect all 128 residents in the facility (resident were identified on the census list provided by the Administrator on 02/17/22). This deficient practice could likely prevent residents and any visitors from knowing the facility staffing information. The findings are: A. On 02/27/23 at 9:50 am, during an observation of the facility revealed the Nurse Staffing Information 24 Hour Posting was not posted. B. On 02/27/22 at 10:16 am, during an interview the Administrator confirmed the Nurse Staffing 24 Hour Posting was not posted in a prominent place.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 41755 Based on observation, record review and interview, the facility failed to ensure that 1 (R #92) of 3 (R #29, R #76, and R #92) residents reviewed for behavioral-emotional health concerns/issues were receiving necessary behavioral health care to meet their needs. This deficient practice could likely result in residents having a decline in their physical, mental, and psychosocial well-being. The findings are: A. On 02/21/23 at 11:23 AM, during an interview, R #92 began to cry and stated I want to go home. B. On 02/23/23 at 2:36 PM, during an observation of R #92, R #92 was observed sitting in his wheelchair in the hallway near his room. R #92 had a flat affect (lack of emotion to incidents, events or surroundings) and was staring at the wall. C. On 02/24/23 at 8:01 AM, during an observation of R #92, R #92 was observed sitting in his wheelchair in the hallway. R #92 again had a flat affect, was staring away and was not interacting with any staff or residents around him. D. Record review or R #92's Physician's Orders revealed: 1. Active Physician's order 08/03/21 Behavioral Health Obtain as needed Consult and treatment for patient health and comfort 2. Active Physician's order 11/17/21 Consult (name of behavioral health services company) E. Record review of R #92'S Electronic Medical Record (EMR) revealed that he had not received any behavioral health consults or services. F. On 02/23/23 at 3:32 PM, during an interview with Social Worker (SW), SW confirmed that R #92 did have two orders in place for behavioral health services and stated she was not sure why R #92 had not started services yet. G. On 02/24/23 at 8:05 AM, during an interview the SW confirmed that there was no indication that there was any follow-up completed by the facility to determine the status of the referral. The SW worker provided a letter from the behavioral health services company H. Record review of the letter from [Name of behavioral health services company] dated 02/23/23 stating a referral for (name of R #92) was received on 11/17/2021. However, due to limitations of EMR ., unable to ascertain if the referral was completely processed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38148 Based on observation and interview, the facility failed to properly store medications in the medication carts for all 25 residents on the 200 (Memory Care) unit, 38 residents on the 300 (east) hallway, and 18 residents on the 400 (main) hallway (residents were identified by the resident matrix provided by the Administrator on 02/16/23), when they failed to ensure medications were not expired (expired medications can be less effective or risky due to a decrease in strength). This deficient practice could result in residents having adverse side effects. The findings are: Memory Care Unit Medication Cart A. On 02/24/23 at 10:33 AM, during observation of the medication cart in the Memory Care unit revealed: 1. Over the Counter (OTC), Liquid pain relief with an expiration date of January 2022 2. Tramadol (used to relieve moderate to moderately severe pain, including pain after surgery) 50 mg expired 02/23/23 B. On 02/24/23 at 10:33 AM during an interview, LPN #21 confirmed that that Pain relief and Tramadol were expired. Main Hall Medication Cart C. On 02/24/23 at 11:44 AM, during observation of the medication cart for the Main Hall revealed: 1. Simethicone (to relieve the painful symptoms of too much gas in the stomach and intestines) OTC gel caps 180 mg expired January 2023, 2. Memantine (used to treat moderate to severe Alzheimer's disease : A progressive disease that destroys memory and other important mental functions.) 10 mg expired 12/31/22 D. On 02/24/23 at 11:58 AM, during an interview, LPN #22 confirmed that the Simethicone OTC, Memantine 10 mg were expired. East Hall Medication cart E. On 02/24/23 at 12:10 PM, during observation of the medication cart for the East Hall revealed: 1. Oxycodone (a strong, semi-synthetic opioid used medically for treatment of moderate to severe pain.) 5 mg expired in April 2022 F. On 02/24/23 at 12:25 PM, during an interview, LPN #23 confirmed of that the Oxycodone 5 mg was expired in April 2022. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 02/27/23 at 4:00 PM, during an interview, the DON stated that expired meds shouldn't be on the medication cart and her expectation is that they should be removed from the cart. 41755

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38148 Based on observation and interview, the facility failed to store and serve food under sanitary conditions in accordance with professional standards of food service safety this could likely affect all 127 residents in the facility (residents were identified by the resident matrix provided by the Administrator on 02/16/23), who eat food prepared in the kitchen, when they failed to: 1. Ensure food items in the dry pantry were labeled and dated, 2. Perform hand hygiene, 3. Properly cover unused containers of food. If the facility fails to adhere to safe food handling practices, hygiene practices, and safe food storage, residents are likely to be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are: A. On 02/20/23 at 9:35 AM, during an observation of the kitchen's dry pantry revealed: 1. Container of instant mash potatoes did not have a lid/cover, 2. A bottle of Vanilla flavoring with date of 11/21 did not have a lid/cover, and 3. The following food opened without a label to identify the product and no opened date or expiration date: a. A bag of powdered milk, b. 2 bags of rolls, c. A container of breadcrumbs, d. A container of flour. B. On 02/20/23 at 9:50 AM, during an observation in the kitchen, Dietary Aid (DA) #21 was observed prepping drinks for lunch by labeling and dating the lids. DA #21 was wearing gloves and did not remove them or perform hand hygiene. C. On 02/20/23 at 10:00 AM, during an interview, the Dietary Manager confirmed the items in the dry pantry should be covered, labeled and dated and also confirmed that dietary staff should be performing hand hygiene between tasked.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47510 Based on record review and interview, the facility failed to ensure documents in resident records were complete and accurate for 1 (R #32) of 1 (R #32) residents sampled for care planning, when they failed to accurately document resident's non-compliance with fluid restrictions. This deficient practice could likely result in staff not having the information they need to provide competent, comprehensive care and services if vital information is missing from the resident's medical documents. The findings are: A. Record review of R #32's Orders dated 04/22/2021 revealed: 1. Monitor Daily Fluid Restriction Total: 1500 ml (milliliter) . B. On 02/20/23 at 3:52 PM, during an interview R #32 stated that he only drinks soda that his family brings for him. C. On 02/22/23 at 1:44 PM, during an interview and observation of R #32's room, RN #11 confirmed that there were sodas in R #32's room. RN #11 said that the resident doesn't usually drink sodas. RN #11 was asked how staff monitored R #32 for the soda intake if it is in his room and he said, well he usually doesn't drink it. He then stated they don't monitor it. D. Record review of R #32's TAR (Treatment Administration Record) dated February 2023 revealed: 1) Document noncompliance and refusals of care i.e.; leg wraps, fluid restriction every shift -Start Date-10/13/2020 documented as compliance with fluid restrictions. E. Record review of R #32's ADL (Activities of Daily Living) sheet dated February 2023, revealed fluid intake was only documented for meals. F. On 02/22/23 at 2:38 PM, during an interview with the DON she confirmed that R #32's has soda in his room and non-compliance should be noted on the TAR and wasn't.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 47510 Based on record review and interview, the facility failed to provide Abuse Prohibition training (abuse prevention), to 1 (LPN #12) of 3 (RN #11, LPN #12, and LPN #13) staff sampled for training. This deficient practice could likely result in staff not knowing who, what, and when to report abuse, neglect, and exploitation. The findings are: A. Record review of LPN #12's training transcript revealed that abuse prohibition was not complete. B. On 02/27/23 at 10:58 AM, during an interview with Human Resources (HR), HR confirmed that LPN #12 had not completed the required abuse prohibition training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47510 Based on record review and interview the facility failed to have required in-service training for nurse aides for 3 (CNA #11, CNA #12, and CNA #13) of 3 (CNA #11, CNA #12, and CNA #13) CNA's sampled for training when they failed to ensure: 1. Abuse Prohibition Training (abuse prevention), was complete for CNA #11 and CNA #13, 2. Annual trainings are based, in part on facility assessment and performance evaluations for CNA #11, CNA #12, and CNA #13. The deficient practice could likely lead to the CNA's not receiving the continuing education needed to provide competent care to the residents. The findings are: A. Record review of CNA #11's training transcript revealed that Abuse Prohibition was not complete. B. Record review of CNA #13's training transcript revealed that Abuse Prohibition was not complete. C. On 02/27/23 at 10:58 AM, during an interview with Human Resources (HR), HR confirmed that CNA #11 and CNA #13 had not completed the required Abuse Prohibition training and they had been employed for over a year. D. On 02/27/23 at 11:21 AM, during an interview with the DON, she stated she does not base the training on the facility assessment and performance evaluations.