STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366158	A. Building B. Wing	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion Rehabilitation and Nursing Center	13900 Bennett Road North Royalton, OH 44133

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, record review, and staff interviews, the facility failed to maintain Resident #13's dignity when the resident's indwelling urinary catheter collection bag was uncovered and visible to others. This affected one resident (#13) of 40 residents observed for dignity. The facility census was 40. Findings include: Review of Resident #13's medical record revealed the resident was admitted to the facility on [DATE]. The medical diagnoses revealed the resident had an indwelling urinary catheter for a diagnosis for benign prostatic hyperplasia (BPH) with lower urinary tract symptoms. Review of the most recent Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition and required extensive assistance of two staff for bed mobility and transfers, total dependence for toilet and bathing with one assist by staff and extensive assistance with one assist for dressing and hygiene. The assessment indicated the resident had an indwelling urinary catheter and was frequently incontinent of bowel. Review of the monthly physician's orders for October 2022 revealed an order for a 16 french foley catheter. Review of the plan of care, dated 10/07/22, revealed the resident had an indwelling catheter related to obstructive and reflux uropathy. Interventions included check tubing for kinks each shift, monitor and document intake and output as per facility policy, monitor for signs and symptoms of pain and discomfort due to catheter, monitor, record, report to physician for signs and symptoms of urinary tract infection (UTI), no output, deepening of urine color, increased pulse, increased temperature, foul smelling urine, fever, chills, altered mental status, changing behavior or change in eating patterns. Observation on 10/3/22 at 11:09 A.M. of Resident #13's indwelling urinary catheter revealed the collection bag was without a cover and urine was visible from the hallway. Interview on 10/03/22 at 11:14 A.M. with STNA #512 confirmed resident's indwelling urinary catheter collection bag lacked a cover and the urine in the collection bag was visible from the hallway by anyone passing by the room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/04/22 at 9:29 A.M. with the DON confirmed indwelling urinary catheter collection bags are to have privacy covers in place for dignity issues. Observation on 10/11/22 at 9:40 A.M. of Resident #13's indwelling urinary catheter revealed the collection bag was without a cover and urine was visible from the hallway by anyone passing by the room. Interview on 10/11/22 at 9:40 A.M. with STNA #515 confirmed Resident #13's indwelling urinary catheter collection bag lacked a cover and the urine in the collection bag was visible from the hallway.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on record review, staff interview, and policy review, the facility failed to ensure two residents (#12 and #16) had their code status in both the electronic medical records and the hard chart. This affected two residents (#12 and #16) of 19 residents reviewed for code status. The facility census was 40. Findings include: 1. Record review for Resident #16 revealed an admitted [DATE]. Diagnosis included spastic hemiplegia affecting right dominant side, chronic respiratory failure, and personal history of traumatic brain injury. Record review of the Admission Minimum Data Set (MDS) 3.0 assessment, dated 07/25/22, revealed Resident #16 had a Brief Interview of Mental Status Score of 14 out of 15 (cognitively intact). Resident #16 required limited assistance with bed mobility and transfers, was independent with locomotion and eating. Record review in the medical records for Resident #16 revealed there was no code status documented in the hard chart or electronic medical system. Interview on 10/06/22 at 10:37 A.M. with Director of Nursing (DON) revealed she was not sure who would be responsible to obtain the code status but maybe Social Services or the floor nurse would be responsible. The DON confirmed Resident #16 had no code status in the medical record. Interview on 10/06/22 at 10:45 A.M. with Social Worker Designee (SWD) #505 revealed she would usually go over the code status in the care plan meeting then nursing would complete the orders. SWD #505 reviewed the care plan meeting dated 07/22/22 at 2:17 P.M. and confirmed Do Not Resuscitate (DNR) was marked in the notes with no further information. SWD #505 revealed she thought she sent Resident #16's father the information and was waiting for it to return. SWD #505 verified there was no code status documented for Resident #16 in the medical records. Interview on 10/06/22 at 10:50 A.M. with Resident #16 revealed no one had spoken with him regarding advanced directives. Interview on 10/06/22 at 10:53 A.M. with Licensed Practical Nurse (LPN) #407 verified Resident #16 had no code status in the medical records. 43061 2. Review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses of traumatic subdural hemorrhage, cerebral infarction, seizures, acquired deformity of lower leg, hemiplegia affecting left nondominant side, anxiety disorder, post-traumatic stress disorder, depressive disorder, psychosis, and dementia. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Annual Minimum Data Set (MDS) 3.0 assessment, dated 07/15/22, revealed Resident #12 had intact cognition and required extensive assistance of two for bed mobility and transfers, total dependence for toilet and bathing with one assistance and extensive assistance with one assist for dressing and hygiene Review of the physician's orders for Resident #12 revealed there was an order for full code status in the electronic medical record. Review of Resident #12's hard medical chart revealed no document to indicate full code status. Interview on 10/04/22 at 9:15 A.M. with State tested Nursing Assistant (STNA) #509 confirmed there was no code status in the hard medical chart. STNA #509 reported the code status was supposed to be in the front of the hard medical chart or under the advance directives tab. Interview on 10/04/22 at 9:17 A.M. with Licensed Practical Nurse (LPN) #158 confirmed there was no code status in the hard medical chart. LPN #158 reported there was supposed to be code status in the hard medical chart, even full code status. LPN #158 showed the surveyor a blank, full code status document as an example of what was to be placed in the hard medical chart under the advance directive tab in addition to the code status being in the electronic medical record. Interview on 10/04/22 at 9:29 A.M. with the Director of Nursing (DON) confirmed code status was to be entered in the electronic medical record and in the hard medical chart. The DON confirmed there was no code status in the the hard medical chart. Review of the facility policy titled; Advanced Directives dated December 2016 revealed each residents advance directives are located within his/her medical record including hard copies in the hard chart. These include but are not limited to resuscitation directives.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, staff interviews, physician interviews, nurse practitioner interviews, and review of facility policy on change in resident conditions, the facility failed to timely notify the physician of significant changes in condition for three residents (#90, #92 and #95). This resulted in Immediate Jeopardy and potential for serious life-threatening harm when Resident #90 and #92 developed critically high blood sugars over 400 milligrams per deciliter (mg/dl) with no notification to the physician. In addition, Resident #95's physician was not notified of missed doses of blood thinning medication ordered to treat blood clots and missed doses of blood pressure medication to prevent high blood pressures. The lack of notification resulted in Resident #90 and #92 not receiving timely treatment for critically high blood sugars and Resident #95 not receiving timely treatment for blood clots and blood pressure. This affected three Residents (#95, #92, and #90) of five residents reviewed for physician notification. The facility census was 40. On 10/12/22 at 12:55 P.M., the Administrator, Regional Director of Clinical Services (RDCS) #500, and Regional Director of Operation (RDO) #502 were notified Immediate Jeopardy began on 09/24/22 when Resident #90, admitted on [DATE] to the facility with a diagnosis of diabetes and an order for insulin, did not receive any insulin or a blood sugar assessment on 09/24/22. On 09/25/22 at 9:30 P.M. Resident #90's blood sugar was elevated to 451 mg/dL (normal blood sugar is 99 mg/dl) Resident #90's physician or CNP were not notified Resident #90 did not receive insulin on 09/24/22 and the physician or CNP were not notified Resident #90's blood sugar was 451 mg/dL on 09/25/22. The Immediate Jeopardy continued when Resident #95 (admitted to the facility with diagnoses of acute embolism, thrombosis of deep veins of the bilateral lower extremities, and hypertension) failed to receive five doses of the physician ordered medication Eliquis (blood thinning medication used in the treatment of embolism) and seven doses of the physician ordered medication metoprolol (medication used in the treatment of hypertension). Resident #95's physician was not notified the resident failed to receive the ordered medications until Resident #95's CNP #406 was notified by the surveyor on 10/04/22. The Immediate Jeopardy situation continued when Resident #92 (admitted to the facility on [DATE] with a diagnosis of diabetes mellitus) did not receive insulin or blood sugar checks as ordered by the physician on 09/30/22, 10/01/22, 10/02/22 and missed two doses of insulin medication on 10/03/22 until a blood sugar check at 4:30 P.M. on 10/03/22 revealed a blood sugar of 344 mg/dl. On 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451 mg/dl and the physician or CNP were not notified Resident #92 did not receive the ordered insulins or of the critically high blood sugar of 451 mg/dl. The Immediate Jeopardy was removed on 10/13/22 when the facility implemented the following corrective actions: 10/12/22 at 4:07 P.M. Resident # 92 was assessed by Registered Nurse (RN) [NAME] President of Clinical Services (VPCS) #501 for signs and symptoms of hypoglycemia and hyperglycemia related to missed insulin doses and glucose assessments. 10/12/22 at 4:17 P.M. Resident #95 was assessed by RN VPCS #501 for increase signs and symptoms of deep vein thrombosis (DVT) or clots in lower extremities noted for missed doses of Eliquis. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10/12/22 at 5:29 P.M. Resident #90 was assessed by RN VPCS #501 for signs and symptoms of hyperglycemia and hypoglycemia related to blood sugars and insulins that were omitted related to elevated blood sugars and residents' current medications were reviewed. 10/12/22 at 4:27 P.M. CNP #162 was notified of medication errors for resident # 92 on all insulins not being administered and missed blood sugar assessments and current orders verified by RN VPCS #501. 10/12/2022 at 4:29 P.M. CNP #162 was notified of medication errors for Resident #90 not being administered, missed blood sugar assessments, elevated blood sugars, and not being notified. Current medication orders were verified by RN VPCS #501. 10/12/22 at 4: 45 P.M. an ad hoc QAPI meeting was conducted and in attendance were the Administrator, RN VPCS #501, RDO #502, RDCS RN #500, Maintenance Director #145, Business Office Manager (BOM) #133, Social Services #505, Admission Director #504, Housekeeping Director #130, Activity Director #101, Therapy Director #508, Minimum Data Assessment (MDS) Licensed Practical Nurse (LPN) #146, Scheduler #148 and Medical Director #405 by phone. A discussion took place about the initial audits and missed doses of insulin and anticoagulation therapy. Topics also included the admission process, timely notification to the physician on admission and verification of orders, change in condition or status including missed doses of medication, controlled substance emergency kit, STAT emergency orders and deliveries, emergency medications, obtaining fingerstick glucose level and notifying the physician, administering medications and insulin administration. QAPI will be held weekly for four weeks, and notification will occur at the time of omission or change in condition to primary care or CNP by floor nurse if no response from physician or CNP occurs the Medical Director will be contacted within 24 hours by nurse management 10/12/2022 at 4:50 P.M. Medical Director #405 was notified of medication errors on Resident #95 and missed Eliquis doses on admission and current orders confirmed for all medications by RN VPCS #501. 10/12/22 at 4:55 P.M. RN VPCS #501 audited all residents with anticoagulants (Resident # 20, #15 and #6) for September and October 2022 to ensure no other residents had missed anticoagulants or failure to notify. 10/12/22 at 5:00 P.M. All residents (#21, 31, 93) with insulin and blood sugar assessments were reviewed to ensure no other residents had missed doses or failure to notify by RN VPCS #501. 10/12/22 at 5:10 P.M. review of notification with CNP #162, Medical Director #405, CNP #418, and Physician #410. Notification of blood sugars for all parties is per their sliding scale orders or if it is routine insulin only notify for less than 60 or greater than 400 per the clarification obtained by RN VPCS #501. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10/12/2022 by 6:00 P.M. All licensed nursing staff were educated on the admission process and timely notification of admission to the physician. All licensed nursing staff were also educated on timely notification of changes to physicians which included missed doses of medications, sliding scale insulin and blood sugar assessments by RDCS RN #500. Nurses having not been educated will not start a shift prior to education from DON/designee. Agencies nurses were contacted who are working the next few days and educated by RDCS RN #500. Agency nurses who are not on the schedule or replace call offs will be required to review and sign education in agency book related to the admission process, timely notification to the physician on admission and verification of orders, change in condition or status including missed doses of medication, controlled substance emergency kit, STAT emergency orders and deliveries, emergency medications, obtaining fingerstick glucose level and notifying the physician, administering medications and insulin administration. The licensed nursing staff receiving the education included: Agency nurses: Five LPNs and four RNs; Facility Nurses: Three LPNS, one RN, and two Medication Aides 10/12/22 at 10:00 P.M. New admissions for the last 30 days and currently are in the facility were audited for the discharge orders from hospital to ensure orders were accurate and all CNPs and Physician had been notified of the admissions by VPCS RN #501. 10/12/22 at 10:30 P.M. Blood sugars were reviewed to ensure assessment was complete and that appropriate sliding scale was administered per physician order or that physician was notified by VPCS RN #501. 10/12/22 at 11:58 P.M. A review of facility Point Click Care (PCC) records was completed to ensure no new admissions were admitted today by VPCS RN #501. 10/13/22 by 11:00 P.M. a review of residents was completed by DON/designee for change in condition and notification of change to physician. 10/13/22 by 11:59 P.M. the physician for any residents identified with a change in condition will be notified. Audits will be conducted by DON or the Nursing Home Administrator daily to ensure admission orders are completed accurately and medications are administered as per physician orders and physician was notified timely of new admission for four weeks then weekly for four weeks then ongoing. Audits will be conducted by DON or the Nursing Home Administrator daily to ensure that insulin is administered and that blood sugar assessments are completed as per physician orders and that missed doses or abnormal blood glucose are reported to the physician timely for 4 weeks then weekly for four weeks then ongoing. All findings will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations. Although the Immediate Jeopardy was removed on 10/13/22, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure ongoing compliance. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: 1. Record review for Resident #95 revealed an admitted [DATE]. Diagnoses included acute embolism and thrombosis of unspecified deep veins of unspecified lower extremities, heart failure, hypertension, and unspecified intellectual disabilities. Record review of the care plan dated 10/04/22 for Resident #95 revealed Resident #95 had a deep vein thrombosis (DVT). Interventions included to give medications as ordered. Resident #95 also had a care plan that included the resident had congestive heart failure. Interventions included to give cardiac medications as ordered. Record review of the Admission Summary dated 10/01/22 at 6:52 A.M. revealed Resident #95 was alert to person and place but not situation. Resident #95 was admitted with bilateral lower extremity DVTs. Resident #95 was on Eliquis for DVTs. Record review of the discharge physician orders from Hospital #404 for Resident #95 dated 09/30/22 revealed orders for Eliquis five mg take two tablets (10 mg) by mouth twice daily for 12 doses and on 10/04/22 start taking Eliquis one tablet (five mg) by mouth daily. Orders also included metoprolol tartrate 12.5 mg every eight hours for hypertension. Record review of the Medication Administration Record (MAR) for Resident #95 revealed Resident #95 did not receive Eliquis until 10/03/22 at 6:00 P.M. (admitted [DATE], five doses not administered) and did not receive metoprolol until 10/03/22 at 2:00 P.M. (seven doses not administered). Interview on 10/04/22 at 11:00 A.M. with Resident #95 revealed Resident #95 was confused and unable to answer questions appropriately. Resident #95 was rambling incoherently. Interview on 10/04/22 at 3:36 P.M. with LPN #407 confirmed Resident #95 was confused. LPN #407 revealed when Resident #95 was admitted on [DATE] at 11:00 P.M., the admitting nurse did not put all needed personal information for Resident #95 into the electronic medical system (she left out Resident #95's sex). Because there was information left out, the orders did not transmit to pharmacy, so the pharmacy was unaware of Resident #95's admission to the facility and medication orders. LPN #407 confirmed the medications were written on the MAR for the nurses to see and none of the nurses had corrected the error so Resident #95 did not receive her medications as ordered until LPN #407 corrected it on 10/03/22. LPN #407 verified Resident #95 did not receive medications as per the physician orders. Record review on 10/04/22 at 3:13 P.M. revealed Medical Director #405 (the Physician to care for Resident #95 while at the facility) was not notified of Resident #95's admission or the missed medications. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/04/22 at 6:33 P.M. with Certified Nurse Practitioner (CNP) #406 (who worked directly with Physician #405) confirmed the physician assigned to Resident #95, Physician #405, was not notified of the admission to verify medications and was not notified of Resident #95 not receiving medications. CNP #406 revealed she checked with all physicians on call including Physician #405 and none had been notified of the resident's admission or missed medications. CNP #406 revealed this would be a concern for Resident #95. CNP #406 included skilled assessments including vital signs should have been done daily and Resident #95 receiving her medications would have been of utmost importance to prevent a possible pulmonary embolism and/or possible death from complications. CNP #406 revealed on 10/03/22 a nurse left a message for her that a resident missed their medications, the nurse did not leave the residents name, or the name of the medications missed. Interview on 10/06/22 at 2:00 P.M. with CNP #406 revealed she visited Resident #95 on 10/05/22 and found the medication Eliquis was originally ordered by the hospital to decrease on 10/04/22 to five mg daily. CNP #406 revealed the facility did not clarify with the physician or herself how to correctly dose the Eliquis since Resident #95 did not receive the medication for the first five doses and the facility did not decrease the dose as per the hospital orders on 10/04/22. CNP #406 revealed the medication needed to be adjusted with the missed doses. Record review of the MAR revealed Resident #95 continued to receive Eliquis 10 mg by mouth two times a day from 10/03/22 at 6:00 P.M. through 10/05/22 at 6:00 A.M. when CNP #406 decreased the medication to five mg two times a day. 2. Record review for Resident #92 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus and essential hypertension. Record review of the care plan dated 10/03/22 revealed Resident #92 had interventions including diabetes medication as ordered by the physician, monitor, and document any signs or symptoms of hyperglycemia. The resident had potential for altered cardiovascular status related to hypertension. Interventions included medications as ordered. Record review of the Nursing Progress note dated 09/29/22 at 9:49 P.M. completed by Registered Nurse (RN) #408 revealed Resident #92 was admitted to the facility around 6:50 P.M. Resident #92 was pleasant, cooperative and was alert and oriented to person, place, and time. Record review of the physician orders dated 09/30/22 for Resident #92 included insulin glargine 100 units per milliliter (ml,) inject 12 units subcutaneously (SQ) at bedtime. Orders also included Humalog insulin inject as per sliding scale if 151mg/dl - 200 mg/dl give 2 units; 201mg/dl - 250 mg/dl give 3 units; 251mg/dl - 300 mg/dl give 4 units; 301mg/dl - 350 mg/dl give 5 units; 351 mg/dl - 400 mg/dl give 6 units, SQ three times a day related to diabetes mellitus. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of physician orders for September and October 2022 revealed the order for the Humalog insulin inject as per sliding scale was discontinued by RN #408 on 09/30/22. The orders further revealed the Humalog insulin was to be replaced by Admelog Solostar insulin 100 units per milliliter (u/ml) solution inject as per sliding scale: if 151mg/dl - 200 mg/dl give 2 units; 201 mg/dl - 250 mg/dl give 3 units; 251mg/dl - 300 mg/dl give 4 units; 301 mg/dl - 350 mg/dl give 5 units; 351mg/dl - 400 mg/dl give 6 units SQ before meals and if over 400 mg/dl call the physician or CNP. The order for the Admelog Solostar was not processed until 10/03/22 at 4:30 P.M. when LPN #407 initiated the order. The physician or CNP were not notified Resident #92 did not receive the sliding scale insulin according to the physician orders on 09/30/22, 10/01/22, 10/02/22 or 10/03/22 until 4:30 P.M. (two missed doses on 10/03/22). Record review of the MAR for September and October 2022 revealed Resident #92 did not receive her insulin glargine (100 units per ml, inject 12 units SQ at bedtime) on 09/30/22, 10/01/22, or 10/02/22. Resident #92's blood sugar was not being monitored to determine the need for the sliding scale insulin until 10/03/22 at 4:30 P.M. when LPN #407 obtained a BS of 344 mg/dl and initiated the physician order for Admelog Solostar 100 u/ml solution inject as per sliding scale. On 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451 mg/dl. No insulin coverage was given and the physician or CNP were not notified of the blood sugar of 451 mg/dl or the missed routine and sliding scale insulin. Interview on 10/03/22 at 1:46 P.M. with Resident #92 revealed she did not receive her medications as ordered including her insulin and felt the nursing staff was just ignoring her. Resident #92 presented as anxious and concerned. Interview on 10/03/22 at 2:00 P.M. with LPN #407 revealed Resident #92 was always saying she wasn't getting her medications, but she really was. LPN #407 said Resident #92 was just confused. Interview on 10/06/22 at 8:24 A.M. with the DON confirmed Resident #92 did not receive the routine insulin glargine on 09/30/22, 10/01/22 or 10/02/22 and Resident #92 did not receive the sliding scale insulin from 09/30/22 until 10/03/22 at 4:30 P.M. because there was a pharmacy therapeutic interchange on 09/30/22 with Humalog and Admelog insulin. The Admelog should have started as soon as the Humalog was discontinued on 09/30/22 and did not start until 10/03/22 because the nurse removed the Humalog but did not put the Admelog Solostar in. The DON confirmed on 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451 mg/dl and confirmed no insulin was given and the physician was not notified. Interview on 10/10/22 at 1:55 P.M. with Resident #92's primary physician, Physician #161, confirmed he was not updated on Resident #92's blood sugar of 451 mg/dl. Physician #161 confirmed he would have ordered additional medication for Resident #92. Physician #161 reported the facility might have spoken with CNP #162 for the orders. Interview on 10/10/22 at 2:20 P.M. with CNP #162 confirmed he was not notified of Resident #92's blood sugar of 451mg/dl. CNP #162 confirmed he should have been notified and if he were he would have added additional units of insulin to the scheduled sliding scale order at the time the blood sugar was 451 mg/dl. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Resident #90 was admitted on [DATE] with diagnoses include\ing diabetes mellitus, hypothyroidism, hypertension, psychoactive substance abuse, bipolar disorder, cirrhosis of the liver, Review of admission Minimum Data System (MDS) 3.0 dated 09/29/22 revealed Resident #90 had intact cognition. Resident #90 was independent with no set up help for all activities of daily living except for bathing he was independent with set up help. Review of the physician orders for September revealed Resident #90 was ordered Lantus SoloStar Solution pen-injector 100 unit/ml (milliliter), (insulin glargine) inject 10 units SQ at bedtime for diabetes mellitus. Resident #90 received the insulin for a blood sugar of 332 mg/dl on 09/23/22 at 9:30 P.M. then the Lantus SoloStar solution pen-injector 100 unit/ml was discontinued on 09/23/22. A new order was obtained for insulin glargine 100 unit/ml solution pen-injector inject 10 unit subcutaneously at bedtime for diabetes, start date 09/25/22 at 9:30 P.M. There was no order for insulin on 09/24/22 and no insulin was received on 09/24/22. Review of the MARS for September 2022 revealed an order for Lantus SoloStar solution pen-injector 100 unit/ml, (insulin glargine) inject 10 units SQ at bedtime for diabetes mellitus. Resident #90 received the insulin for a blood sugar of 332 mg/dl on 09/23/22 at 9:30 P.M., then the Lantus SoloStar solution pen-injector 100 unit/ml was discontinued on 09/23/22. There was no new order for insulin for 09/24/22. On 09/25/22 a new order for glargine 100 unit/ml to inject 10 unit subcutaneously at bedtime for diabetes mellitus. The MAR revealed on 09/25/22 Resident #90's BS was 451 mg/dl, (critically high blood sugar). Review of MARS for October 2022 revealed an order for Insulin Glargine 100 unit/ml solution pen-injector inject 10 unit subcutaneously at bedtime for diabetes, start date 09/25/22 at 9:30 P.M. On 10/01/22 no insulin was provided as ordered and the physician was not notified of the missed dose of insulin. Interview on 10/12/22 at 9:12 A.M. with Physician #161 revealed Resident #90 should have had an insulin order for 09/24/22. Physician #161 reported the facility might have spoken with NP #162 for the orders. Physician #161 stated he should have absolutely been notified or his NP regarding Resident #90 high blood sugar of 451 mg/dl. Physician #161 confirmed he was not aware Resident #90 had no insulin on 09/24/22 and was not notified of the high blood sugar of 451 mg/dl on 09/25/22. Interview on 10/12/22 at 9:18 A.M. with NP #162 revealed he was not notified of no insulin orders for 09/24/22 or the high blood sugar of 451mg/dl. NP #162 reported he would have ordered insulin on 09/24/22 and ordered additional insulin coverage on 09/25/22 for the high blood sugar of 451mg/dl. NP#162 reported he would expect to be notified of high blood sugars and would have provided additional insulin coverage to prevent symptoms of high blood sugars. Interview on 10/12/22 at 9:40 am with RDCS #500 confirmed insulin was not provided on 09/24/22 for Resident #90, the resident had a high blood sugar on 9/25/22 at bedtime of 451 mg/dl and the physician should have been notified, RDCS #500 confirmed on 10/01/22 insulin was not given per physician order. RDCS #500 reported best practice would be to contact the physician with a blood sugar of 451mg/dl. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility policy titled, Change in a Residents Condition or Status revised December 2016 revealed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical condition and or status. 43061

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review and staff interviews, the facility failed to ensure a resident or resident representative was provided written notification of a resident transfer to the hospital. The facility also failed to notify the ombudsman of the resident's transfer. This affected one (#13) of two residents reviewed for hospitalization . The facility census was 40. Findings include: Review of the medial record for Resident #13 revealed an admitted [DATE] with diagnoses of paraplegia, spinal stenosis, intestinal obstruction, history of traumatic fracture, and benign prostatic hyperplasia with lower urinary tract symptoms. Resident #13 was discharged to the hospital on 06/13/22 due to emesis and intestinal obstruction and returned to the facility on [DATE]. Review of Resident #13's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition. Review of Resident #13's electronic and hard chart medical records revealed no evidence a written notice of transfer was provided to Resident #13 or the resident's representative. The facility also failed to notify the ombudsman of the resident's transfer to the hospital. Interview on 10/18/22 at 2:51 P.M. with [NAME] President of Clinical Services (VPCS) #501 verified the facility did not provide a written notice of transfer to the hospital for Resident #13 or resident representative. VPCS #501 verified the facility did not provide a written notification to the ombudsman. Interview on 10/18/22 at 2:55 P.M. with the Administrator verified the facility did not provide a written notice of transfer to the hospital for Resident #13 or resident representative and did not provide a written notification to the ombudsman. Interview on 10/19/22 at 12:23 P.M. with BOM #133 verified the facility did not provide a written notification to Resident #13 or the ombudsman. Review of facility policy, Transfer or Discharge Notice, revised December 2016, revealed a notice was to be provided in writing to the resident and/or resident representative.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review and interview, the facility failed to ensure bed hold notices were given to Resident #13 and/or their representatives upon transfer to the hospital. This affected one resident (#13) of two residents reviewed for hospitalization . The facility census was 40. Findings include: Review of the medial record for Resident #13 revealed an admitted [DATE] with diagnoses of paraplegia, spinal stenosis, intestinal obstruction, history of traumatic fracture, and benign prostatic hyperplasia with lower urinary tract symptoms and a discharge to the hospital on 06/13/22 and returned to the facility on [DATE]. Review of Resident #13 quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #13 had intact cognition. Review of Resident #13's medical record revealed no evidence that a bed hold notice was provided to Resident #13 or the resident's representative. Interview on 10/18/22 at 2:51 P.M. with [NAME] President of Clinical Services (VPCS) #501 verified the facility did not provide a written bed hold notice for Resident #13. Interview on 10/18/22 at 2:55 P.M. with Administrator verified the facility did not provide a written bed hold notice for Resident #13 or resident representative. Interview on 10/19/22 at 12:23 P.M. with BOM #133 verified the facility did not provide a written bed hold notification to Resident #13 or resident representative. Review of facility policy, Bed-Holds and Returns, revised March 2017, revealed prior to transfer, written will be given to the resident and resident representative explaining bed holds.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42011 Based on record review, facility policy and procedure review, and interviews, the facility failed to ensure a copy of the initial baseline care plan was provided to each resident and/or their representative in a language they could understand within 48 hours of admission to the facility. This affected two residents (#92 and #95) of three residents reviewed for baseline care plans. The facility census was 40. Findings include: 1.Record review for Resident #92 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus, chronic obstructive pulmonary disease, acute cystitis without hematuria, hyperlipidemia, psychoactive substance abuse, anxiety disorder, depression, and essential hypertension. Record review revealed a care plan for Resident #92 was developed 10/03/22. However, there was no evidence it was provided to Resident #92 and/or her representative. Interview on 10/04/22 10:00 A.M. with Resident #92 revealed she had not been provided a copy of the initial care plan. Interview on 10/06/22 at 8:24 A.M. with the DON confirmed there was no evidence Resident #92 and/or her representative were provided a baseline care plan within 48 hours of admission. 2. Record review for Resident #95 revealed an admitted [DATE]. Diagnosis included covid 19, ventral hernia without obstruction, lump in unspecified breast, lymphedema, disease of liver, severe protein calorie malnutrition, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, heart failure, and intellectual disabilities. Record review revealed a care plan for Resident #95 was developed 10/03/22. However, there was no evidence a copy of the care plan was provided to Resident #95 and/or her representative. Interview on 10/04/22 at 9:47 A.M. with Resident #95's representative revealed she had never received any care plan information from the facility. Interview on 10/06/22 at 8:24 A.M. with the DON confirmed there was no evidence Resident #95 and/or her representative were provided a baseline care plan as required within 48 hours of admission. Review of the facility policy titled, Care Plans -Baseline, dated December 2016, revealed to assure the residents immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the residents admission.

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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** 42011 Based on interview and record review, the facility failed to invite Resident #16 to his care conference and failed to ensure the minimum, required interdisciplinary staff members involved in his care and services attended the care conference according to the regulatory requirements. This affected one resident (Resident #16) of three residents reviewed for care planning. The facility census was 40. Findings include: Record review for Resident #16 revealed an admitted [DATE] with diagnoses including spastic hemiplegia affecting right dominant side, chronic respiratory failure, diabetes mellitus, hypertension, contracture of muscle, and personal history of traumatic brain injury. Record review of the Admission Minimum Data Set (MDS) 3.0 assessment, dated 07/25/22, revealed Resident #16 had a Brief Interview of Mental Status (BIMS) score of 14 out of 15 (cognitively intact). Resident #16 required limited assistance with bed mobility and transfers and was independent with locomotion and eating. Record review of the Care Conference Form, dated 07/22/22 at 2:17 P.M., and authored by Social Worker Designee (SWD) #505 for Resident #16 revealed attendance at the meeting consisted of SWD #505 and Business Office Manager (BOM) #133. There was no evidence other members of the interdisciplinary team attended the meeting. The form indicated no concerns at the time of the meeting. There was no further evidence any other care conferences had been held for Resident #16 since 07/22/22. Interview on 10/06/22 at 10:50 A.M. with Resident #16 revealed he had never been invited to, or discussed with any staff member, information regarding any care plan meeting. Resident #16 revealed he would have attended the meeting. Interview on 10/06/22 at 3:27 P.M. with SWD #505 verified Resident #16 was admitted on [DATE], BOM #133 and herself were the only two members present at Resident #16 care conference on 07/22/22. SWD #505 revealed she does not recall if she invited Resident #16, but she was sure she discussed the meeting with Resident #16's dad who was also not at the care conference on 07/22/22. SWD #505 revealed she invited therapy to each meeting, if the resident received therapy, (Resident #16 did not receive therapy at that time), she would also invite the BOM and Minimum Data Set (MDS) Nurse if she was available. SWD #505 confirmed she never invited nurses or State tested Nursing Assistants (STNA) to any care plan meetings, initial or comprehensive, and she never invited a physician or Certified Nurse Practitioner (CNP) to any meetings revealing they were too busy. SWD #505 confirmed the only staff invited to any care plan meetings, initial or comprehensive, were BOM, Therapy, and MDS Nurse when they were available. SWD #505 confirmed Resident #16 had no other care plan meetings since 07/22/22, the comprehensive care plan meeting was not completed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/18/22 at 2:30 P.M. with Regional Director of Clinical Services (RDCS) Registered Nurse (RN) #500 revealed care plan meetings should consist of the MDS Nurse, SWD, Charge Nurse or Unit Manager, STNA, Therapy, Dietary Manager, Activities, BOM, and Physician or Certified Nurse Practitioner (CNP). The Comprehensive Care Plan involving the care plan team should be completed within the first 21 days of admission. Record review of the policy titled, Care Planning dated September 2013 revealed the facilities Care Planning/Interdisciplinary Team (IDT) is responsible for the development of the individualized comprehensive care plan for each resident. A comprehensive care plan is developed within seven days of completion of the resident assessment (MDS). The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes but is not limited to the following personal: The Residents Attending Physician, Registered Nurse (RN) who has responsibility for the resident, Dietary Manager/Dietitian, SW, Activities Director, Therapist, Consultants, DON, Charge Nurse, STNA, Others as appropriate or necessary. The resident, the resident's family and or the residents legal representative, guardian or surrogate are encouraged to participate in the development and the revision to the residents care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure fingernail and toe nail care was provided for Resident #95 who was not able to provide the care for herself. This affected one (#95) of three residents reviewed for activities of daily living (ADL) care. The facility census was 40. Findings include: Record review for Resident #95 revealed an admitted [DATE] with diagnoses including acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity and intellectual disabilities. Record review of the care plan dated 10/03/22 revealed Resident #95 had an ADL self care performance deficit related to decreased mobility function. Interventions included to check nail length and trim and clean on bath day and as necessary. Interview on 10/04/22 at 11:00 A.M. with Resident #95 revealed Resident #95 was alert but unable to answer simple questions. Her verbal response to the surveyor was unintelligible mumbling. Observation on 10/05/22 at 9:40 A.M. of Resident #95's wound care to the left heel with Licensed Practical Nurse (LPN) #407 and State tested Nursing Assistant (STNA) #120 revealed Resident #95's left big toe nail was curved to the side and grown out from the toe approximately two inches beyond the tip of the big toe. The second and fourth toenails were curved under and embedded into the skin with a small amount of dried blood near the second embedded toenail and dried blood was smeared on the bed sheets near the left foot. Resident #95's right foot toe nails were also long and jagged. Resident #95's fingernails were very long in length, unkempt with jagged edges and all 10 fingernails were embedded with a dark brown/black thick dried substance. Interview on 10/05/22 at 9:45 A.M. with LPN #407 confirmed Resident #95's left big toe nail was curved to the side approximately two inches above the tip of the big toe and the second and fourth toenails were curved under and embedded into the skin with a small amount of dried blood near the second embedded toenail and dried blood was smeared on the bed sheets near the left foot. LPN #407 also verified Resident #95's right foot toe nails were also long and jagged and the fingernails were very long in length, unkept with jagged edges with all 10 fingernails embedded with a dark brown/black thick dried substance. LPN #407 explained it was not her responsibility to ensure Resident #95 saw a podiatrist for toe nail care but instead was the Social Workers responsibility. LPN #407 was unable to explain why Resident #95 had not received care and grooming to her fingernails. Interview on 10/05/22 at 9:50 A.M. with STNA #120 revealed Resident #95 had not refused personal care including nail care. STNA #120 revealed at times she was unable to complete all the resident tasks due to there was so much to do and she did not have time. Interview on 10/05/22 at 10:30 A.M. with Social Worker Designee (SWD) #505 revealed she scheduled routine ancillary services and if there was an emergent need the nurse should notify her. SWD #505 said she had not been notified Resident #95 had a need for a podiatrist for toe nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/06/22 at 10:40 A.M. with DON revealed at the time of admission after the resident assessment was completed, if there was a concern or need for podiatry services, the nurse should notify the social worker and the podiatrist could have made a facility visit to care for the residents needs. The DON confirmed fingernails could be attended by the nurse or STNA and should be completed on an as needed basis. Record review of the facility policy titled. Care of Fingernails/Toenails dated October 2010, revealed the purpose of the procedure was to clean the nail bed, to keep nails trimmed, and to prevent infection. Nail care included daily cleaning and regular trimming.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 43061 Based on observation, record review and interviews, the facility failed to ensure therapeutic activities to meet the needs and preferences of the residents were provided during various times of the day including evenings and on weekends. This affected 12 (Residents #3, #5, #7, #12, #13, #15, #19, #21, #25, #28, #31, and #32) of 19 residents reviewed for activities. The facility census was 40. Findings Include: Observation on 10/03/22 at 8:29 A.M. of the activity room on the second floor revealed there were no signs on the windows or doors to the activity room pertaining to any activities being available in the facility. There was no activity in the room during the observation. Interview on 10/03/22 at 10:42 A.M. with Resident #15 revealed she was not able to leave her room and was being provided no room activities. Resident #15 also shared on a day cake was being served to the residents for an activity she was not included in that activity. Resident #15 stated she would like to participate in activities but the staff did not offer her any activities to participate. Review of the activity calendar for the month of September and October 2022 revealed no weekend activities for 09/03/22, 09/04/22, 09/17/22, 09/18/22, 10/01/22, 10/02/22, 10/15/22, 10/16/22, 10/29/22, 10/30/22 and no evening activities provided on any days. The activity calendar listed 2:30 P.M. as the last activity of the day. In September 2022, the smoke break was offered twice a day as the daily activity on 20 out of 30 days for the month. Interview on 10/05/22 at 3:45 P.M. Activities Director (AD) #101 verified there were no evening activities or activities every weekend. AD #101 reported she didn't have the staff to provide every weekend activity. AD #101 reported Resident #15 didn't want to attend activities out of her room and was offered one-to-one activity. Interview on 10/05/22 at 3:55 P.M. with Activities Assistant (AA) #100 verified no evening activities or weekend activities provided every weekend. AA #100 reported she provided one-to-one activity to Resident #15. Interview on 10/06/22 at 8:54 A.M. with the DON verified no evening activities or every weekend activity was provided to the residents. The DON reported the last activity of the day was at 2:30 P.M. The DON added on some days the last activity was at 11:15 A.M. Interview on 10/06/22 at 10:39 A.M. with the Administrator verified no evening activities were provided and only every other weekend activity was provided to the residents. Interview on 10/06/22 at 10:45 A.M. with the Administrator revealed she returned to show this surveyor a sign titled Always Available Activities. The Administrator said the sign was posted on the activity room window and all residents could participate in the self-lead, always available activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/06/22 at 11:47 A.M. with Resident #7, #12, #13, #19, #21, #31, and #32 denied any knowledge of Available Anytime Activities. Residents #7, #12, #13, #19, #21, #31, and #32 reported they never heard of this before. Resident #7, #12, #13, #19, #21, #31, and #32 asked what it was and if it was something new. Interview on 10/11/22 at 7:59 A.M. with AD #101 revealed there was not a sign Always Available Activities posted on activity window until the Administrator put one up on 10/06/22. AD #101 reported she had no log available to show one on one activities were provided to Resident #15 or any resident on one-to-one activities. AD #101 reported she does not keep a log of one-to-one activities provided to residents. During the resident council meeting on 10/11/22 at 10:10 A.M., Residents #3, #5, #25, and #28 voiced concerns related to the lack of evening activities and weekend activities. Resident #3, #5, #25, and #28 denied any knowledge of Available Anytime Activities. Review of facility policy, Activity Program, revised August 2006, revealed activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activities are scheduled seven days a week, at least one evening activity is offered per week, at least two group activities per day are offered on Saturday, Sunday, and holidays, and at least four group activities are offered per day Monday through Friday.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 42011 Based on interview and record review, the facility failed to update quarterly fall risk assessments in order to evaluate the risk for falls and interventions to prevent falls for Resident #7. This affected one (Resident #7) of five residents reviewed for falls. The facility census was 40. Findings include: Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnosis of hemiplegia, hemiparesis, dysphagia following cerebral infarction, cirrhosis of liver, acute respiratory failure with hypoxia, history of healed traumatic fracture, alcohol dependence, mood disorder, psychoactive substance and alcohol abuse, and major depressive disorder. Resident #7 was discharged from the facility on 10/07/22. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 10/03/22, revealed Resident #7 had intact cognition. Review of the falls risk assessments in Resident #7's medical record revealed a fall risk assessment had been completed on 12/09/21 and identified Resident #7 at high risk for falls. There were no additional fall risk assessments completed until 06/01/22 after Resident #7 had a fall. Interview on 10/05/22 at 12:42 P.M. with the Director of Nursing (DON) revealed falls risk assessments were not completed quarterly as required for Resident #7. The DON confirmed a falls risk assessment was completed on 12/9/21 and the next one was completed on 06/01/22 after Resident #7 had a fall. The DON reported the MDS Nurse #146 was in the facility once a week and MDS Nurse #146 was responsible to circulate a list to the nursing staff listing which residents were due to the falls risk assessments. The DON added MDS Nurse #146 was also responsible to follow up in the electronic medical records system to ensure those residents due for falls risk assessments were completed per the list. Interview on 10/05/22 at 1:59 P.M. with MDS Nurse #146 verified the falls risk assessment was not completed on Resident #7 as required. MDS Nurse #146 confirmed a falls risk assessment was completed on 12/9/21 and the next one was completed on 06/01/22 after a fall. MDS Nurse #146 indicated it was her understanding falls risk assessments should be done quarterly, but MDS Nurse #146 would need to check with the DON because she felt that was a nursing question she wanted the DON to answer for the surveyor to make sure it was accurate. Review of the facility policy titled Fall and Fall Risk, Managing, dated 12/2007, indicated the staff would identify interventions related to the resident's specific fall risk to try to prevent falls, based on previous evaluations of the residents fall risk.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview and record review, the facility failed to provide care and treatment to a left heel wound for Resident #95. This affected one Resident (#95) of one residents reviewed for pressure ulcers. The facility census was 40. Findings include: Record review for Resident #95 revealed an admitted [DATE] and diagnoses including lymphedema, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and intellectual disabilities. Record review of the care plan for Resident #95, dated 10/03/22, revealed Resident #95 was at risk for skin breakdown related to decreased mobility. Interventions included pressure reducing cushion to wheel chair and pressure reducing/relieving mattress to the bed. Record review of a nurses note dated 10/01/22 at 6:52 A.M. for Resident #95 revealed Resident #95 arrived at the facility at 11:00 P.M. on 09/30/22 with no distress noted upon arrival and had a wound to the left heel with orders in place. Record review of the nurses note dated 10/01/22 at 7:56 A.M. revealed Resident #95 had a stage two pressure ulcer to the left heel which was pink in color with a scant amount of blood tinged drainage present. The measurement was 1.5 centimeters (cm) in length (L) by 1.3 cm in width (W) x 0.0 cm in depth (D). There was no mention of a right heel wound in the nurses note. Record review of the physician orders for Resident #95 revealed on 10/01/22 an order to cleanse the right heel wound with normal saline, pat dry, apply calcium alginate, abd (an absorbant dressing) and wrap with Kerlix (a gauze wrap) daily. On 10/03/22 a new order for prevalon boots at all times while in bed and on 10/04/22 a new order for a specialized low air loss mattress to maintain skin integrity. Record review revealed no order was in place for the left heel wound. There were no orders in place for the left heel wound. Record review of the Treatment Administration Record (TAR) for Resident #95 revealed treatment to the right heel was done on 10/01/22. No treatment was completed to the right heel on 10/02/22 or 10/03/22. Record review revealed no documentation of a wound to the right heel. There were no treatments on the TAR for the left heel wound. Observation on 10/04/22 at 2:30 P.M. revealed Resident #95 lying in bed. Resident #95 did not have a low air loss (LAL) mattress on the bed and was not wearing prevalon boots as ordered. There were no prevalon boots near the resident or in her room at the time of the observation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/04/22 at 2:35 P.M. with Licensed Practical Nurse (LPN) #407 confirmed Resident #95 was not on a LAL mattress and did not have prevalon boots in place. LPN #407 confirmed the facility had the boots and mattress in stock and she was not sure why they were not in place. LPN #407 confirmed Resident #95 did not have a treatment order for the left heel and the treatment order for the right heel was not completed on 10/02/22, 10/03/22, or 10/04/22. Record review for Resident #95 revealed a physician order dated 10/04/22 at 3:04 P.M. completed by LPN #407 revealed an order to cleanse the left foot with soap and water, rinse, pat dry and pad and protect daily and as needed. Observation on 10/05/22 at 9:40 A.M. of wound care to the left heel for Resident #95 with LPN #407 and State tested Nursing Assistant (STNA) #120 revealed an undated dressing was removed from the left heel. There were multiple dried blood stain smears on Resident #95's sheet near the left foot. LPN #407 measured Resident #95's wound to the left heel at 2.3 cm (L) by 1.4 cm (W) by 0.1 cm (D). LPN #407 verified the findings at the time of the observation. Record review of the facility policy titled, Wound Care dated October 2010, revealed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify that there is a physicians order for the procedure, document the type of wound care given and the date and time the wound care was given.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, record review, and interview, the facility failed to ensure foley catheter care was provided as ordered by the physician. This affected one resident (Resident #13) of one resident reviewed for catheter care. The facility census was 40. Findings include: Review of Resident #13's medical record revealed he was admitted to the facility on [DATE] with diagnoses of paraplegia, spinal stenosis, intestinal obstruction, history of traumatic fracture, and benign prostatic hyperplasia with lower urinary tract symptoms. Resident #13 was admitted to the facility with an indwelling urinary catheter for a diagnosis for benign prostatic hyperplasia (BPH) with lower urinary tract symptoms. Review of the most recent Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #13 had intact cognition and required extensive assistance of two for bed mobility and transfers, total dependence for toilet and bathing with one assistance and extensive assistance with one assist for dressing and hygiene. The assessment indicated Resident #93 had an indwelling urinary catheter and was frequently incontinent of bowel. Review of the monthly physician's orders for October 2022 revealed an order for Foley Catheter Care every shift and as needed and document output. The order was initiated on 07/15/22. Review of the Treatment Administration Records (TARS) for September 2002 and October 2022 revealed catheter care was not provided on 09/06/22 night shift, 09/13/22 night shift, 09/14/22 night shift, 09/17/22 night shift, 09/26/22 night shift, 09/27/22 night shift, 09/28/22 day and night shifts, 09/29/22 night shift, 09/30/22 night shift, 10/03/22 night shift, 10/04/22 day and night shift, 10/05/22 night shift, 10/07/22 night shift, 10/08/22 night shift, 10/09/22 night shift, 10/10/22 day shift, 10/12/22 night shift, 10/17/22 night shift, and 10/18/22 day and night shift. Review of the plan of care, dated 10/07/22, revealed the resident had an indwelling catheter related to obstructive and reflux uropathy. Interventions included check tubing for kinks each shift, monitor and document intake and output as per facility policy, monitor for signs and symptoms of pain and discomfort due to catheter, monitor, record, report to physician for signs and symptoms of urinary tract infection (UTI), no output, deepening of urine color, increased pulse, increased temperature, foul smelling urine, fever, chills, altered mental status, changing behavior or change in eating patterns. change Interview on 10/05/22 at 3:04 P.M. with Resident #13 revealed he did not receive catheter care today and other days. Resident #13 reported he does not receive catheter care on every shift. Interview on 10/05/22 at 3:16 P.M. with the DON revealed nursing provides the catheter care to residents with urinary catheters. The DON verified catheter care was not being done as ordered per physician for resident #13 and catheter care was not signed off on the TAR as completed on day shift by RN #159 who was responsible for Resident #13's catheter care on day shift 10/05/22. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/06/22 at 8:25 A.M. with Resident #13 revealed no catheter care was provided on any shift yesterday. Resident #13 asked the surveyor if he was supposed to let the staff know he needed catheter care provided because it was not being done and he did not know why. Interview on 10/06/22 at 8:27 A.M. with LPN #409 revealed LPN #409 told the surveyor it was the State tested Nursing Assistants (STNA) responsibility to perform catheter care not the nurses. Interview on 10/06/22 at 8:30 A.M. with the DON revealed urinary catheter care was to be provided by nurses not the STNA's. The DON reported STNA's can empty urinary catheter bags and put a cover on the bag. The DON verified again catheter care was not being provided to Resident #13 as ordered by the physician. The DON reported the nurse was to provide urinary catheter care and the resident was not required to ask or let them know it needed done. Observation of urinary catheter care on 10/06/22 at 2:00 P.M. with LPN #409 revealed supplies were gathered, explained procedure to Resident #13, consent for surveyor to observe, privacy curtain pulled, and door shut to maintain privacy. LPN #409 raised the bed, performed hand hygiene, and applied gloves. LPN #409 provided warm water in a basin and urinary catheter care was provided while maintaining infection control measures. Interaction between resident and LPN #409 was professional and kind. No concerns or issues noted with the catheter care. Interview on 10/17/22 at 12:23 P.M. with LPN #513 revealed urinary catheter care was provided by the nurse and only Resident #13 had a urinary catheter. Review of the facility policy titled, Catheter Care, Urinary, revised September 2014, revealed the purpose of the procedure was to prevent catheter-associated urinary tract infections.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview and record review, the facility failed to notify the physician, Physician #405, of Resident #95's admission to the facility. This affected one resident, Resident #95, of five residents reviewed for physician notification of admission. The facility census was 40. Findings include: Record review for Resident #95 revealed an admitted [DATE]. Diagnosis included acute embolism and thrombosis of unspecified deep veins of unspecified lower extremities, heart failure, hypertension and unspecified intellectual disabilities. Record review of the care plan dated 10/04/22 for Resident #95 revealed Resident #95 had a deep vein thrombosis (DVT). Interventions included to give medications as ordered. Record review of the Admission Summary dated 10/01/22 at 6:52 A.M. revealed Resident #95 was alert to person and place but not situation. Resident #95 was admitted with bilateral lower extremity DVT's. Resident (#95) was on Eliquis for DVT's. Record review of the medical record for Resident #95 revealed Physician #405 was assigned to be the primary care physician for Resident #95. Record review revealed no documentation of Physician #405 being notified of Resident #95's admission to the facility or orders being verified. Interview on 10/04/22 at 11:00 A.M. with Resident #95 revealed Resident #95 was unable to answer questions appropriately. Interview on 10/04/22 3:13 P.M. with Certified Nurse Practitioner (CNP) #406 (who worked directly with Physician #405) confirmed she was never notified of Resident #95's admission. CNP #406 revealed a nurse notified her Monday (10/03/22) an admission came but the nurse never gave the residents name or further information. CNP #406 revealed she would check with the primary physician the resident would have been assigned to, Physician #405, to verify if he was notified of the new admission. Interview on 10/04/22 at 6:33 P.M. with CNP #406 confirmed she spoke with the physician assigned to Resident #95, Physician #405, and he was not aware or was never notified of Resident #95 being admitted to the facility or any information regarding Resident #95. CNP #406 revealed she also checked with all physicians on call at the office and none had been notified of Resident #95's admission. CNP #406 reiterated on 10/03/22 a nurse left a message for her that a resident was admitted and missed their medications but the nurse did not leave the residents name or the name of the medications missed. Interview on 10/06/22 at 3:56 P.M. with the DON confirmed physicians should be notified and verify orders at the time of a residents admission to the facility. The DON revealed there was no specific written policy for notification of admission.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview and record review, the facility failed to act upon the pharmacy review recommendations for two residents, Resident #12 and #14. This affected two residents, Resident #12 and #14, of five residents reviewed for pharmacy reviews. The facility census was 40. Findings include: 1. Record review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnosis included schizoaffective disorder, anxiety disorder, vascular dementia, major depressive disorder with psychotic symptoms. Record review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had severe cognitive impairment. Resident #14 received antipsychotic medications, antidepressant medication, and opioid medications daily. Record review of the care plan dated 06/25/20 revealed antipsychotic medications were used for the diagnosis of depression and schizophrenia. Interventions included to attempt dose reductions as indicated per evaluation if clinically indicated. Record review of the physician orders for Resident #14 for October 2021 revealed orders for the psychoactive medications risperidone (an antipsychotic medication) 0.5 milligrams (mg) two times a day (initiated 08/14/20), remeron (an antidepressant medication) 15 mg once a day (initiated 02/09/21), lexapro (an antidepressant medication) 20 mg once a day (initiated 02/09/21) and benztropine mesylate one mg two times a day for anti-tremor (initiated 07/06/22). Record review of the document titled Note To Attending Physician/Prescriber, dated 10/29/21, and completed by Pharmacist #401 revealed Resident #14 was receiving the following psychoactive medications, risperidone 0.5 milligrams (mg) two times a day, remeron 15 mg once a day and lexapro 20 mg once a day, that are due for review. Pharmacist #401 added for the physician to please evaluate Resident (#14) for trial dose reduction. Record review of the facility document titled Note To Attending Physician/Prescriber, dated 01/28/22, and completed by Pharmacist #401 revealed Resident #14 was receiving risperidone which may cause involuntary movements, including tardive dyskinesia (TD), but an Abnormal Involuntary Movement Scale (AIMS) or DISCUS (dyskenisia identification system condensed user scale) assessment was not documented in the resident record within the previous six months. Pharmacist #401 added early detection of involuntary movements is one of the best opportunities to avoid irreversible TD. Record review of the Note To Attending Physician/Prescriber document dated 10/29/21 and 01/28/22 completed by Pharmacist #401 were both blank where the physician would make a note addressing the recommendation and apply a signature to indicate that physician received the recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Medication Administration Record (MAR) for October 2021 through December 2021 revealed Resident #14 received or was offered risperidone 0.5 milligrams (mg) two times a day, remeron 15 mg once a day and lexapro 20 mg once a day. Record review of the MAR for October 2022 revealed Resident #14 continued to receive risperidone 0.5 milligrams (mg) two times a day, remeron 15 mg once a day and lexapro 20 mg once a day. Record review of the medical record for Resident #14 revealed three AIMS tests were completed since admission, 06/12/19, 02/10/21, and 06/23/21. Record review of the medical records for Resident #14 revealed no documentation in the records were found confirming the Note To Attending Physician/Prescriber dated 10/29/21 and 01/28/22 completed by Pharmacist #401 were ever addressed by the attending physician/prescriber. Interview on 10/06/22 at 3:56 P.M. with the DON confirmed the pharmacy recommendation for Resident #14 from 10/29/21 and 01/28/22 were not addressed by the attending physician/prescriber. The DON confirmed AIMS tests should be completed upon initiation of the medication and every six months thereafter and the AIMS tests were not completed every six months for Resident #14. 43061 2. Resident #12's medical record review revealed an admitted [DATE] with diagnoses including traumatic subdural hemorrhage, cerebral infarction, seizures, hemiplegia affecting left nondominant side, anxiety disorder, post-traumatic stress disorder, depressive disorder, psychosis, and dementia. Review of the Annual Minimum Data Set (MDS) 3.0 assessment, dated 07/15/22, revealed the resident had intact cognition, little interest, or pleasure in doing things, trouble falling sleeping and feeling tired or little energy. Record review of the care plan dated 10/10/22 revealed antipsychotic medications used for the diagnosis of unspecified psychosis and post-traumatic stress disorder. Interventions included to administer psychotropic medications as ordered by physician, monitor for side effects, consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly, and monitor, document, and report as needed any adverse reactions psychotropic medications. Record review of the physician orders for Resident #12 for October 2022 revealed orders for Remeron tablet 7.5 mg at bedtime for depression, Duloxetine Hydrochloric Acid (HCl) capsule delayed release sprinkle 60 mg give 90 mg everyday for depression and Risperdal tablet 25 mg give 1 tabled twice a day for antipsychotic medications. Record review of the Medication Administration Record (MAR) for October 2022 revealed Resident #12 received Remeron 7.5 mg at bedtime, Duloxetine HCl capsule delayed release sprinkle, 90 mg every day, and Risperdal tablet 25 mg 1 tablet twice a day as ordered. Interview on 10/06/22 at 3:29 P.M. with the Director of Nursing (DON) revealed there were no pharmacy recommendations to evidence Resident #12 was being reviewed for gradual dose reductions. The DON could not provide any for the last six months to a year for Resident #12, as requested by the surveyor. The DON explained the pharmacy reviews were not being consistently done for all residents in the facility.

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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** 42011 Based on observation, interview and record review, the facility failed to attempt a gradual dose reduction for psychotropic medications used for one resident, Resident #14, of five residents reviewed. The facility census was 40. Findings include: Record review of the medical record for Resident #14 revealed an admitted [DATE] and diagnoses including schizoaffective disorder, anxiety disorder, vascular dementia, major depressive disorder, and recurrent severe with psychotic symptoms. Record review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had severe cognitive impairment. Resident #14 required extensive assistance of two staff with bed mobility and transfers and supervision with use of a walker and wheelchair. Resident #14 received antipsychotic, antidepressant, and opioid medications daily. Record review of the care plan dated 06/25/20 revealed antipsychotic medications used for the diagnosis of depression and schizophrenia. Interventions included to monitor behavior symptoms and side effects such as tardive dyskinesia, tremors, muscle spasms, movement of tongue and jaw. Attempt dose reductions as indicated per evaluation if clinically indicated. Record review of the physician orders for Resident #14 for October 2021 revealed orders for risperidone 0.5 milligrams (mg) two times a day (initiated 08/14/20), Remeron 15 mg once a day (initiated 02/09/21), Lexapro 20 mg once a day (initiated 02/09/21) and benztropine mesylate one mg two times a day for anti-tremor (initiated 07/06/22) Record review of the document titled Note To Attending Physician/Prescriber dated 10/29/21 completed by Pharmacist #401 revealed Resident #14 was receiving the following psychoactive medications, risperidone 0. 5 milligrams (mg) two times a day, Remeron 15 mg once a day and Lexapro 20 mg once a day, that were due for review for a gradual dose reduction. Pharmacist #401 added to please evaluate Resident #14 for trial dose reduction. Record review of the Note To Attending Physician/Prescriber dated 01/28/22 completed by Pharmacist #401 revealed Resident #14 was receiving risperidone which may cause involuntary movements, including tardive dyskinesia (TD), but an Abnormal Involuntary Movement Scale (AIMS) assessment was not documented in the resident record within the previous six months. Pharmacist #401 added early detection of involuntary movements is one of the best opportunities to avoid irreversible TD. Record review of the document Note To Attending Physician/Prescriber dated 10/29/21 and 01/28/22 completed by Pharmacist #401 were both blank where the physician would make a note addressing the recommendation add a signature to indicate the physician had received and made a decision on the recommendation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion Rehabilitation and Nursing Center	13900 Bennett Road North Royalton, OH 44133

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Medication Administration Record (MAR) for October 2021 through December 2021 revealed Resident #14 received or was offered risperidone 0.5 milligrams (mg) two times a day, Remeron 15 mg once a day and Lexapro 20 mg once a day. Record review of the MAR for October 2022 revealed Resident #14 continued to receive risperidone 0.5 milligrams (mg) two times a day, Remeron 15 mg once a day and Lexapro 20 mg once a day. Record review of the medical record for Resident #14 revealed three AIMS test were completed since admission, 06/12/19, 02/10/21, and 06/23/21. The AIMS test was scored zero through 28. The higher the score, the greater the impact of observed movements. On 06/12/19 the AIMS test completed by Licensed Practical Nurse (LPN) #402 revealed Resident #14 scored a four, (the jaw had minimal mouth opening, lateral movement). The Aims test dated 06/23/21 completed by LPN #403 revealed a score of three (the jaw had minimal mouth opening, lateral movement). Record review of the medical records for Resident #14 revealed no evidence in the records confirming the Note To Attending Physician/Prescriber dated 10/29/21 and 01/28/22 completed by Pharmacist #401 were ever addressed by the attending physician. Observation on 10/03/22 at 4:00 P.M. revealed Resident #14 sitting in the activity room coloring. Resident #14's lower jaw had involuntary rapid movement with open mouth, shaking as she colored. Interview on 10/03/22 at 4:30 P.M. with LPN #409 confirmed Resident #14's lower jaw had involuntary rapid movement. LPN #409 revealed Resident #14 started medication benztropine mesylate one milligram (mg) two times a day for tremors in July 2022 due to the rapid jaw movement. Interview on 10/06/22 at 3:56 P.M. with DON confirmed the recommendation from 10/29/21 and 01/28/22 were not addressed by the attending physician/prescriber. The DON confirmed AIMS tests should be completed upon initiation of the medication and every six months thereafter. The DON confirmed the AIMS test were not completed every six months for Resident #14 and revealed she had no policy regarding the reduction of psychotropic medication use. Interview on 10/10/22 at 1:15 P.M. with Resident #14's primary care physician, Physician #410, confirmed he did not receive the pharmacy recommendations for Resident #14 and had not attempted a dose reduction of psychotropic medications for Resident #14. Physician #410 verified Resident #14 had Tardive Dyskenesia from the psychotropic medication use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, record review, interview, and review of manufacture's guidelines, the facility failed to ensure a medication error rate of less than five percent. Three errors occurred within 27 opportunities for error resulting in a medication error rate of 11.11 %. This affected three of five residents (Resident #2, #13, and #93) observed during the mediation administration observation. The facility census was 40. Findings include: 1. Review of Resident #2's medical records revealed an admitted [DATE] with diagnoses including psychosis, schizophrenia, major depressive disorder, hypertension, thalassemia, lymphoid leukemia, anxiety disorder, history of malignant carcinoid tumor of rectum and history of malignant neoplasm of large intestine. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had intact cognition and was independent for all activities of daily living (ADL's) with no set up required. Review of the physician orders for October 2022 revealed Resident #2 was to receive Tamsulosin Hydrochloric Acid (HCl) 0.4 milligram (mg) to give two capsules by mouth (two capsules to equal 0.8 mg) every day related to personal history of other malignant neoplasm of large intestine. Observation of medication administration on 10/05/22 at 9:05 A.M. revealed Registered Nurse (RN) #159 pop only one capsule from the package of Tamsulosin Hydrochloric Acid (HCl) 0.4 mg into the medicine cup. RN #159 reported she had a total of seven pills in the medicine cup. The correct total should have been eight pills in the medicine cup. RN #159 confirmed she was ready to administer to Resident #2 when this surveyor stopped her and asked to check on the correct count of medication. RN #159 went back to the medication cart and confirmed for Tamsulosin (HCl) 0.4 mg she only popped one pill into the medicine cup, and it should have been two pills. Interview on 10/05/22 with RN #159 verified Resident #2 had only one capsule in the medicine cup before she was going to administer to resident and the count of medications (pills/capsules) in medicine cup she prepared to administer was not correct. Interview on 10/05/22 at 11:14 A.M. with the Director of Nursing (DON) confirmed Resident #2 was to receive two capsules of Tamsulosin HCl 0.4 mg to equal a total of 0.8 mg not one capsule, which was only half the dose the physician ordered. 2. Review of Resident #13's medical records revealed an admitted [DATE] with diagnoses paraplegia, covid-19, fall, low back pain, spinal stenosis, intestinal obstruction, history of traumatic fraction, laparoscopic surgical procedure converted to open procedure, benign prostatic hyperplasia with lower urinary tract symptoms, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 10/01/22 revealed the resident had potential for alteration in pain and discomfort related to fracture of vertebra and spinal stenosis. Interventions included administer analgesia as per orders, give half hour before treatments or care, anticipate the resident's need for pain relief and respond immediately to any complaint of pain, attempt non-pharmological interventions prior to giving medication, and monitor, record, report to nurse any signs or symptoms of non-verbal pain, and notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Review of the Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had intact cognition. Activities of daily living (ADL's) were extensive with two plus assistance for bed mobility, transfer and toilet. Resident #13 required extensive with one assistance for dressing and hygiene. Resident #13 was independent with eating with set up help and bathing was total with one assistance. Resident #13 had a Foley catheter and was frequently incontinent of stool. Review of the physician order for October 2022 revealed Resident #13 was ordered Lidocaine Patch 4% (for pain) apply topically in the morning to right abdomen (12 hours on, 12 hours off). Observation of medication administration on 10/05/22 at 9:38 A.M. revealed RN #159 reported there was no Lidocaine Patch available. RN #159 checked both the medication carts thoroughly and was not able to find the Lidocaine Patch 4%. RN #159 reported she would need to re-order and did not give Resident #13 his Lidocaine Patch 4% as ordered by the physician. Review of the Medication Administration Records (MARS) for October revealed Resident #13 did not receive his Lidocaine Patch 4% as ordered by the physician. Interview on 10/05/22 at 9:44 A.M. with RN #159 confirmed Lidocaine Patch 4% was not available to administer per ordered by the physician. RN #159 confirmed Resident #13 did not receive his Lidocaine Patch 4% as ordered by the physician. Interview on 10/05/22 at 11:19 A.M. with the DON confirmed Resident #13 did not receive his ordered medication, Lidocaine Patch 4% was not available to administer per ordered by the physician. 3. Review of Resident #93's medical records revealed an admitted [DATE] with diagnoses including type two diabetes mellitus, necrotizing fasciitis, cellulitis of right lower limb, local infection of the skin and subcutaneous tissue, bradycardia, fatty liver, hypertension, fracture right femur, streptococcal arthritis right hip, chronic kidney disease, history of covid-19, schizoaffective disorder, and bipolar disorder. Review of the care plan dated 09/16/22 revealed the resident had type two diabetes mellitus with foot ulcer. Interventions included diabetes medication as ordered by doctor, monitor and document for side effects and effectiveness, fasting serum blood sugar as ordered by doctor, identify areas of non-compliance with diabetic management, if infection is present, consult doctor regarding any changes in diabetic medications, monitor, document, and report any signs and symptoms of hyperglycemia, monitor, document and report any signs and symptoms of hypoglycemia, monitor, document, and report compliance with diet, and refer to podiatrist, foot care nurse to monitor and document foot care needs and to cut long nails. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed had Resident #93 had intact cognition. Resident #93 was independent with no set up help for bed mobility and eating. Supervision with one-person physical assist for transfers, supervision with set up help only for dressing, supervision with no set up help for hygiene, and supervision with no set up help for bathing. Resident #93 was occasionally incontinent of bladder and bowel. Review of the physician order for October 2022 revealed Resident #93 was ordered Humalog KwikPen solution pen-injector 100 unit/milliliter (ml) (Insulin Lispro), one unit dial) to be administered per sliding scale (SS). Inject as per SS if the blood sugar was 151 mg per deciliter (dl) to 200 mg/dl give two units, if 201 mg/dl to 250 mg/dl give four units; if 251 mg/dl to 300 mg/dl give five units; if 301 mg/dl to 350 mg/dl give six units; if 351 mg/dl to 400 mg/dl give seven units and if over 400 mg/dl give nine units and call the medical doctor, subcutaneously before meals for diabetes mellitus and give Humalog kwikpen solution pen-injector to give 7 units straight before meals. Resident #93's 11:00 A.M. blood sugar on 10/06/22 was 245. Per SS order Resident #93 was to receive seven units of SS insulin and four units of the straight insulin to equal a total of 11 units. During medication administration observation on 10/06/22 at 11:09 A.M., LPN #407 prepared Resident #93's Lispro KwikPen insulin (a disposable prefilled insulin pen used for injection) by securing a new needle onto the KwikPen and set the dial at 11 units of insulin per sliding scale of 4 and straight order for 7 units. LPN #407 did not prime the insulin pen as required before drawing up insulin to ensure correct insulin coverage would be provided to Resident #93. LPN #407 used hand sanitizer and entered Resident #93's room and administered insulin into Resident #93's right arm. Interview on 10/06/22 at 11:20 A.M. with LPN #407 confirmed she did not prime the insulin pen due to being nervous and said I forgot. Interview on 10/06/22 at 11:48 A.M. with the DON confirmed insulin pens are required to be primed (discard two units) for two units before drawing up insulin dosage to ensure correct dosage of insulin was provided to the resident. Review of manufacturer's instructions for Insulin Lispro Injection KwikPen (pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf) revealed prime before each injection, if you do not prime before each injection, you may get too much or too little insulin. Review of the facility policy, Administering Medications, revised December 2012, revealed all medications must be administered in accordance with the orders, including any required time frame.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, interviews with facility staff and resident and review of the facility policy for administering medications, the facility failed to ensure four Residents (Residents #95, #92, #90 and #40) received significant medications as ordered by the physician. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm when Resident #90, who had a diagnosis of diabetes mellitus (DM), did not receive insulin or a blood sugar (BS) assessment on 09/24/22 resulting in an elevated BS of 451 mg/dl (normal BS is 99 milligrams per deciliter (mg/dl)), Resident #95 was admitted to the facility with diagnoses including acute embolism (obstruction of an artery usually by a blot clot or air bubble) and thrombosis (blood clot) of deep veins of the bilateral lower extremities and did not receive five doses of the ordered medication Eliquis (blood thinner) and seven doses of the ordered medication metoprolol (used to decrease high blood pressure) and Resident #92, who was admitted to the facility with a diagnosis of diabetes did not receive routine ordered insulin medication on 09/30/22, 10/01/22, or 10/02/22 and Resident #92's BS was not monitored before meals as ordered between 09/30/22 to 10/03/22 with use of a sliding scale insulin if the blood sugar level was 151 mg/dl or higher. On 10/03/22 at 4:30 P.M. Resident #92's blood sugar was 344 mg/dl, and on 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451mg/dl. In addition, a deficient practice that did not rise to the level of Immediate Jeopardy was identified related to the facility's failure to administer insulin or monitor blood glucose levels per physician order for Resident #40 on 08/26/22 and again the morning of 08/27/22. This affected four of five residents reviewed for significant medication errors. The facility census was 40. On 10/12/22 at 1:01 P.M., the Administrator, RDCS #500, and Regional Director of Operation (RDO) #502 were notified the Immediate Jeopardy began on 09/24/22 when Resident #90, admitted to the facility with diabetes, did not receive insulin medication or a blood sugar assessment. On 09/25/22 at 9:30 P.M., Resident #90's BS elevated to 451mg/dl. Resident #95 was admitted to the facility with acute embolism and thrombosis of deep veins of the bilateral lower extremities and missed five doses of the ordered medication Eliquis and seven doses of the ordered medication metoprolol. Resident #92 was admitted to the facility with a diagnosis of diabetes on 09/29/22. Resident #92 did not receive her routine ordered insulin medication at bedtime on 09/30/22, 10/01/22, or 10/02/22. Resident #92's blood sugar (BS) was not monitored before meals as ordered with use of a sliding scale insulin if the blood sugar level was 151mg/dl or higher, resulting in a BS of 344 mg/dl on 10/03/22 at 4:30 P.M. and on 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451mg/dl. The Immediate Jeopardy was removed on 10/12/22 when the facility implemented the following corrective actions: 10/12/22 at 4:07 P.M. Resident # 92 was assessed by Registered Nurse (RN) [NAME] President of Clinical Services (VPCS) #501 for signs and symptoms of hypoglycemia and hyperglycemia this time related to missed insulin doses and glucose assessments. 10/12/22 at 4:17 P.M. Resident #95 was assessed by RN VPCS #501 for increase signs and symptoms of deep vein thrombosis (DVT) or clots in lower extremities noted for missed doses of Eliquis. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10/12/22 at 5:29 P.M. Resident #90 was assessed by RN VPCS #501 for signs and symptoms of hyperglycemia and hypoglycemia related to blood sugars and insulins that were omitted related to elevated blood sugars and residents' current medications were reviewed. 10/12/22 at 4:27 P.M. CNP #162 was notified of medication errors for resident # 92 on all insulins not being administered and missed blood sugar assessments and current orders were verified by RN VPCS #501. 10/12/2022 at 4:29 P.M. CNP #162 was notified medication errors for Resident #90 not being administered, missed blood sugar assessments, elevated blood sugars, and not being notified. Current medication orders were verified by RN VPCS #501. 10/12/22 at 4:45 P.M. An ad hoc QAPI meeting was conducted and in attendance was the Administrator, RN VPCS #501, RDO #502, RDCS #500, Maintenance Director #145, Business Office Manager (BOM) #133, Social Services #505, Admission Director #504, Housekeeping Director #130, Activity Director #101, Therapy Director #508, Minimum Data Assessment (MDS) Licensed Practical Nurse (LPN) #146, Scheduler #148 and Medical Director #405 by phone. A discussion of initial audits and missed doses of insulin and anticoagulation therapy was held. Topics discussed included the admission process and how to correctly input orders to the pharmacy, timely notification to the physician on admission and verification of orders, change in condition or status including missed doses of medications, controlled substance Emergency Kit, STAT emergency orders and deliveries, emergency medications, obtaining a fingerstick and notification to physician, administering medications and insulin administration. It was determined QAPI will be held weekly for 4 weeks. Notification to the physician will occur at the time of omission of an order or change in condition to primary care or NP by floor nurse if no response from physician or (Certified Nurse Practitioner (CNP)) occurs and the Medical Director will be contacted within 24 hours by nurse management. 10/12/2022 at 4:50 P.M. Medical Director #405 was notified of medication errors on Resident #95 and missed Eliquis doses on admission and current orders confirmed for all medications by RN VPCS #501. 10/12/22 at 4:55 P.M. All residents with anticoagulants (Resident # 20, 15, 6) were reviewed to ensure no other doses of anticoagulants had been missed per audits conducted by RN VPCS #501. 10/12/22 at 5:00 P.M. All residents (#21, 31, 93) with insulin and blood sugar assessments were reviewed by RN VPCS #501 to ensure no other residents had missed doses. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10/12/2022 by 6:00 P.M. All licensed staff were educated on admission process, timely notification of admission to physician, and how to correctly input orders to the pharmacy. All licensed staff were also educated on timely notification of changes to physicians which included missed doses of medications, sliding scale insulin and blood sugar assessments by RDCS #500. Nurses who have not been educated will not start shift prior to education from DON/designee. Agency nurses were contacted who are working the next few days and educated by RDCS #500. Education is expected to be completed by 10/14/2022. Agency nurses who are not on the schedule or replace call offs will be required to review and sign education in agency book related to admission process and how to correctly input orders to the pharmacy, timely notification to physician on admission and verification of orders, change in condition or status including missed doses of medications, controlled substance Emergency Kit, STAT Emergency orders and deliveries, emergency medications, obtaining a fingerstick and notification to physician, administering medications and insulin administration. The following staff were educated on 10/12/22: Agency nurses: five LPNs and four RNs and facility employees: three LPNs, one RN and two Medication Aides. 10/12/22 at 6:10 P.M. All insulin medication for residents # 92,90,21, 31, 93, was checked and present to ensure that insulin can be administered per order or sliding scale by RN RDCS #500. 10/12/22 at 6:15 P.M. Resident #90, Resident #92, and Resident #95, medications were reviewed by RN, RDCS #500, to ensure all medications were present for administration. 10/12/22 at 7:30 P.M. Medication carts were compared to Medication Administration Records were checked and all residents' medications are present by RN RDCS #500. 10/12/22 at 10:00 P.M. RN VPCS #501 audited all new admissions for the last 30 days who currently are in the facility to ensure discharge orders from the hospital were reviewed, orders were accurate, and the Physician was notified of the admission. 10/12/22 at 10:30 P.M. Blood sugars were reviewed to ensure assessment was complete and that appropriate sliding scale was administered per physician order or that physician was notified by RN VPCS #501 of clinical services. Audits will be conducted by DON or the Administrator daily to ensure admission orders are completed accurately and medications are administered as per physician orders and physician was notified timely of new admission for four weeks then weekly for four weeks then ongoing. Audits will be conducted by DON or the Nursing Home Administrator daily to ensure that insulin is administered and that blood sugar assessments are completed as per physician orders and that missed doses or abnormal blood glucose levels are reported to the physician timely for four weeks then weekly for four weeks then ongoing. All findings will be reported to the Quality Assurance Performance Improvement Committee for review and recommendations. Although the Immediate Jeopardy was removed on 10/12/22, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings include: 1. Record review for Resident #95 revealed an admitted [DATE]. Diagnosis included acute embolism and thrombosis of unspecified deep veins of unspecified lower extremities, heart failure, hypertension, and unspecified intellectual disabilities. Record review of the care plan dated 10/04/22 for Resident #95 revealed Resident #95 had a diagnosis of deep vein thrombosis (DVT). Interventions included to give medications as ordered. Resident #95 also had a care plan that included the resident had congestive heart failure. Interventions included to give cardiac medications as ordered. Record review of the Admission Summary dated 10/01/22 at 6:52 A.M. revealed Resident #95 was alert to person and place but not situation. Resident #95 was admitted with bilateral lower extremity DVTs and was on Eliquis for treatment of the DVTs. Record review of the discharge physician orders from Hospital #404 for Resident #95 dated 09/30/22 revealed orders for Eliquis five milligrams (mg) take two tablets (10 mg) by mouth twice daily for 12 doses and on 10/04/22 start taking Eliquis one tablet (five mg) by mouth daily. Orders also included metoprolol tartrate 12.5 mg every eight hours for hypertension. Record review of the Medication Administration Record (MAR) for Resident #95 revealed Resident #95 did not receive Eliquis until 10/03/22 at 6:00 P.M. (admitted [DATE], five doses not administered) and Resident #95 also did not receive metoprolol until 10/03/22 at 2:00 P.M. (seven doses not administered). Interview on 10/04/22 at 11:00 A.M. with Resident #95 revealed Resident #95 was confused and unable to answer questions appropriately. Resident #95 was rambling incoherently. Interview on 10/04/22 at 3:36 P.M. with LPN #407 confirmed Resident #95 was confused. LPN #407 revealed when Resident #95 was admitted on [DATE] at 11:00 P.M., the admitting nurse did not put all needed personal information for Resident #95 into the electronic medical system (she left out Resident #95's sex). Because there was information left out, the orders did not transmit to the pharmacy, so the pharmacy was unaware of Resident #95's admission to the facility and medication orders. LPN #407 confirmed the medications were written on the MAR for the nurses to see and none of the nurses had corrected the error. As a result, Resident #95 did not receive her medications as ordered until LPN #407 corrected it on 10/03/22. LPN #407 verified Resident #95 did not receive medications per physician orders. Record review on 10/04/22 at 3:13 P.M. revealed Medical Director #405 (the primary physician to care for Resident #95 while at the facility) was not notified of Resident #95's admission or the missed medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/04/22 at 6:33 P.M. with CNP #406 (who worked directly with MD #405) confirmed the physician assigned to Resident #95, MD #405, was not notified of the admission to verify medications and was not notified of Resident #95 not receiving medications. CNP #406 revealed she checked with all physicians on call including Physician #405 and none had been notified of the resident's admission or missed medications. CNP #406 revealed this would be a concern for Resident #95 explaining skilled assessments including vital signs should have been done daily and Resident #95 receiving her medications would have been of upmost importance to prevent a possible pulmonary embolism and/or possible death from complications. CNP #406 revealed on 10/03/22 a nurse left a message for her that a resident missed their medications, the nurse did not leave the residents name, or the name of the medications missed. Interview on 10/06/22 at 2:00 P.M. with CNP #406 revealed she visited Resident #95 on 10/05/22 and found the medication Eliquis was originally ordered by the hospital to decrease on 10/04/22 to five mg daily. CNP #406 revealed the facility did not clarify with the physician or herself how to correctly dose the Eliquis since Resident #95 did not receive the medication for the first five doses and the facility did not decrease the dose per the hospital orders on 10/04/22. CNP #406 revealed the medication needed to be adjusted with the missed doses. Record review of the MAR revealed Resident #95 continued to receive Eliquis 10 mg by mouth two times a day from 10/03/22 at 6:00 P.M. through 10/05/22 at 6:00 A.M. when CNP #406 decreased the medication to five mg two times a day. 2. Record review for Resident #92 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus and essential hypertension. Record review of the care plan dated 10/03/22 revealed Resident #92 had diabetes mellitus. Interventions included medication as ordered by the physician, monitor, and document any signs or symptoms of hyperglycemia (symptoms include confusion). The resident had potential for altered cardiovascular status related to hypertension. Interventions included medications as ordered. Record review of the Nursing Progress note dated 09/29/22 at 9:49 P.M. completed by Registered Nurse (RN) #408 revealed Resident #92 was admitted to the facility around 6:50 P.M. Resident #92 was pleasant, cooperative and was alert and oriented to person, place, and time. Record review of the physician orders dated 09/30/22 for Resident #92 included insulin glargine 100 units per milliliter (ml,) inject 12 units subcutaneously (SQ) at bedtime. Orders also included Humalog insulin inject as per sliding scale (SS) if 151mg/dl - 200 mg/dl give 2 units; 201mg/dl - 250 mg/dl give 3 units; 251mg/dl - 300 mg/dl give 4 units; 301mg/dl - 350 mg/dl give 5 units; 351 mg/dl - 400 mg/dl give 6 units, SQ three times a day related to diabetes mellitus. Record review of physician orders for September and October 2022 revealed the order for the Humalog insulin inject as per sliding scale was discontinued by RN #408 on 09/30/22. The orders further revealed the Humalog insulin was to be replaced by Admelog Solostar insulin 100 units per milliliter (u/ml) solution inject as per sliding scale: if 151mg/dl - 200 mg/dl give 2 units; 201 mg/dl - 250 mg/dl give 3 units; 251mg/dl - 300 mg/dl give 4 units; 301 mg/dl - 350 mg/dl give 5 units; 351mg/dl - 400 mg/dl give 6 units SQ before meals and if over 400 mg/dl call the physician or CNP. The order for the Admelog Solostar was not processed until 10/03/22 at 4:30 P.M. when LPN #407 initiated the order. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview and observation on 10/03/22 at 1:46 P.M. with Resident #92 revealed she did not receive her medications as ordered including her insulin and felt the nursing staff was just ignoring her when she tried to tell them she was not getting her medications. Throughout the interview, Resident #92 presented as anxious as she spoke about not getting her medications. Interview on 10/03/22 at 2:00 P.M. with LPN #407 revealed Resident #92 was always saying she wasn't getting her medications and according to LPN #407, Resident #92 was just confused. LPN #407 indicated the resident was getting her medications. Record review of the progress note for Resident #92 dated 10/03/22 at 2:49 P.M. completed by LPN #407 revealed Resident #92 had increased anxiety causing her to itch and request medication. Record review of the progress note for Resident #92 dated 10/03/22 at 3:20 P.M. completed by LPN #407 revealed Resident #92 was very confused throughout the day forgetting she was on isolation. The note indicated the resident had received her medication. LPN #407 added she reminded Resident #92 throughout the day she had received her medications. Record review of the MAR for September and October 2022 revealed Resident #92 did not receive her insulin glargine (100 units per ml, inject 12 units SQ at bedtime) on 09/30/22, 10/01/22, or 10/02/22. Resident #92's blood sugar was not being monitored according to the physician orders to determine the need for the sliding scale insulin from 09/30/22 to 10/03/22 at 4:30 P.M. On 10/03/22 at 4:30 P.M. LPN #407 obtained a BS on Resident #92 indicating 344 mg/dl. LPN #407 initiated the physician order for Admelog Solostar 100 u/ml solution inject as per sliding scale and administered insulin coverage. On 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451 mg/dl. No further assessment or interventions were implemented for the elevated blood sugar. Interview on 10/06/22 at 8:24 A.M. with the DON confirmed Resident #92 did not receive the routine insulin glargine on 09/30/22, 10/01/22 or 10/02/22 and Resident #92 did not receive the sliding scale insulin from 09/30/22 until 10/03/22 at 4:30 P.M. because there was a pharmacy therapeutic interchange on 09/30/22 with Humalog and Admelog insulin. The Admelog should have started as soon as the Humalog was discontinued on 09/30/22 and did not start until 10/03/22. The nurse removed the Humalog but did not put the Admelog Solostar in the electronic records. The DON confirmed on 10/04/22 at 6:30 A.M. Resident #92's blood sugar was 451mg/dl. The DON confirmed the medication was held and the physician was not notified. The DON revealed the facility had a system failure with new admissions and staff not putting correct orders in the electronical medical system. Phone interview on 10/06/22 at 8:50 A.M. with Registered Nurse (RN) #408 confirmed RN #408 discontinued Resident #92 sliding scale insulin orders on 09/30/22 without a physician order to discontinue the orders. RN #408 revealed she discontinued the order in error. The DON was also present during the phone interview with RN #408. Interview on 10/10/22 at 1:55 P.M. with Resident #92's primary physician, Physician #161 confirmed he was not updated on Resident #92's blood sugar of 451mg/dl. Physician #161 confirmed he would have ordered additional medication for Resident #92. Physician #161 reported the facility might have spoken with CNP #162 for the orders. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/10/22 at 2:20 P.M. with CNP #162 confirmed he was not notified of Resident #92's blood sugar of 451 mg/dl. CNP #162 confirmed he should have been notified and if he were he would have added additional units of insulin to the scheduled sliding scale order at the time the blood sugar was 451 mg/dl. 3. Resident #90 was admitted on [DATE] with diagnoses including diabetes mellitus, hypothyroidism, hypertension, psychoactive substance abuse, bipolar disorder, and cirrhosis of the liver. Review of admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #90 had intact cognition. Resident #90 was independent with no set up help for all activities of daily living except for bathing, he was independent with set up help. Review of the physician orders for September 2022 revealed Resident #90 was ordered Lantus SoloStar Solution pen-injector 100 unit/ml (milliliter), (insulin glargine) inject 10 units subcutaneously at bedtime for diabetes). Resident #90 received the insulin for a blood sugar of 332 mg/dl on 09/23/22 at 9:30 P.M., then the Lantus SoloStar solution pen-injector 100 unit/ml was discontinued on 09/23/22. A new order for Insulin glargine 100 unit/ml solution pen-injector inject 10 unit subcutaneously at bedtime for diabetes, start date 09/25/22 at 9:30 P.M. There was no order for insulin on 09/24/22 that replaced the discontinued order of 09/23/22. No insulin was received on 09/24/22. Review of the MARs for September 2022 revealed an order for Lantus SoloStar solution pen-injector 100 unit/ml, (insulin glargine) inject 10 units subcutaneously at bedtime for diabetes mellitus. Resident #90 received the insulin for a blood sugar of 332 mg/dl on 09/23/22 at 9:30 P.M. then the Lantus SoloStar solution pen-injector 100 unit/ml was discontinued on 09/23/22. There was no new order for insulin for 09/24/22. On 09/25/22 a new order for glargine100 unit/ml inject 10 unit subcutaneously at bedtime for diabetes mellitus. On 09/25/22 Resident #90's blood sugar was 451mg/dl. Review of the MARs for October 2022 revealed an order for Insulin glargine 100 unit/ml solution pen-injector inject 10 unit subcutaneously at bedtime for diabetes, start date 09/25/22 at 2130. On 10/01/22 no insulin was provided as ordered per the physician. Interview on 10/12/22 at 9:12 A.M. with Physician #161 revealed Resident #90 should have had an insulin order for 09/24/22. Physician #161 reported the facility might have spoken with CNP #162 for the orders. Physician #161 stated he should have absolutely been notified or his CNP regarding Resident #90's high blood sugar of 451mg/dl. Physician #161 reported he was not aware Resident #90 had no insulin on 09/24/22 and should have had insulin coverage. Interview on 10/12/22 at 9:18 A.M. with CNP #162 revealed he was not notified of no insulin orders for 09/24/22 or the high blood sugar of 451 for Resident #90. CNP #162 reported he would have ordered insulin on 09/24/22 and ordered additional insulin on 09/25/22 for the high blood sugar of 451mg/dl. CNP #162 reported he would expect to be notified of high blood sugars and would have provided additional insulin coverage to prevent adverse symptoms of high blood sugars. Interview on 10/12/22 at 9:40 A.M. with RDCS #500 revealed insulin was not provided on 09/24/22 for Resident #90 and the resident had a high blood sugar on 9/25/22 at bedtime of 451mg/dl. RDCS #500 indicated the physician should have been notified. RDCS #500 confirmed on 10/01/22 insulin was not given per physician order to Resident #90. RDCS #500 reported best practice would be to contact the physician with blood sugar of 451mg/dl. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Review of the medical record for Resident #40 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included acute respiratory failure, diabetes mellitus type two, and hypertension. Review of Resident #40's discharge hospital information dated 08/26/22 and timed at 2:09 P.M. revealed discharge orders for insulin glargine (Lantus Solostar insulin pen) 30 units subcutaneous (SQ) at bedtime, insulin lispro 0-10 units inject 0-10 units (to be used as a sliding scale) SQ with meals and check the resident's blood glucose level four times a day. Continued review revealed no evidence of when the resident last received a blood glucose check or insulin at the hospital. Review of Resident #40's admission assessment revealed the resident was assessed on 8/26/2022 at 9:40 A.M. There is no evidence in the resident's medical record of the actual time of the resident's arrival to the facility. The facility did not initiate any nursing notes regarding Resident #40 until 08/27/22 at 8:50 P.M. Review of Resident #40's August 2022 physician orders revealed the facility did not obtain an order for the resident's insulin lispro solution, insulin glargine solution, or blood sugars until 08/27/22 following the admission on 08/26/22. Review of Resident #40's August 2022 Medication Administration Record revealed the resident did not receive any blood sugar monitoring or insulin until 08/27/22 at 12:00 P.M., at which time Resident #40's blood sugar was 400 mg/dl. Interview on 10/13/22 at 1:23 P.M. with RDCS #500 verified the facility did not initiate Resident #40's insulin glargine 30 units at bedtime, insulin lispro per sliding scale, and blood glucose checks until 08/27/22, resulting in the resident missing blood glucose monitoring and insulin administration on 08/26/22 and the morning of 08/27/22. When the orders were obtained, and initiated the resident's blood glucose was 400 mg/dl. Review of the facility policy, Administering Medications, revised December 2012, revealed all medications must be administered in accordance with the orders, including any required time frame. This deficiency substantiates Complaint Number OH00136495. 42015

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview, record review, and review of the facility policy, the facility failed to offer the pneumococcal vaccine to two residents, Resident #92 and #95, of three residents reviewed The facility census was 40. Findings include: 1. Record review for Resident #92 revealed an admitted [DATE] with diagnoses including type two diabetes mellitus and essential hypertension. Record review of the Nursing Progress note dated 09/29/22 at 9:49 P.M. completed by Registered Nurse (RN) #142 revealed Resident #92 admitted to facility pleasant and cooperative, and alert and oriented to person, place and time. Record review of Resident #92's medical record revealed no indication of Resident #92 being assessed for or offered the pneumococcal vaccine. 2. Record review for Resident #95 revealed an admitted [DATE] with diagnoses including acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity and intellectual disabilities. Interview on 10/04/22 at 9:47 A.M. with Resident #95's representative revealed she had not spoke with anyone from the facility regarding Resident #95's eligability for the pneumococcal vaccine or consent to give or not give the pneumococcal vaccine. Interview on 10/04/22 at 11:00 A.M. with Resident #95 revealed Resident #95 was unable to answer questions appropriately. Interview on 10/18/22 at 10:21 A.M. with the DON verified the facility had not been tracking residents who were offered the pneumococcal vaccine. The DON confirmed Residents #92 and #95 had not been offered the pneumococcal vaccine. Record review of the facility policy titled, Pnemococcal Vaccine dated August 2016 revealed prior to or upon admission the resident will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated will be offered the vaccine series within thirty days of admission to the facility. Assessment of the pneumococcal vaccination status will be conducted within five working days of the residents admission if not conducted prior to admission. Residents or residents representatives have the right to refuse the vaccine, if refused appropriate entries will be documented in each residents medical record indicating the date of refusal of the pneumococcal vaccine.