STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375534	A. Building B. Wing	01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sienna Extended Care & Rehab	9221 Harmony Drive Midwest City, OK 73130

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 46216 Based on record review and interview, the facility failed to ensure: A. resident's family was notified of a change in condition for one (#54) of one resident reviewed for notification of changes and B. the physician was notified in a timely manner of lab results for one (#21) of one resident reviewed for physician notification. The Resident Census and Conditions of Residents, dated 01/03/23, documented a census of 71 residents. Findings: 1. Resident #54 had diagnoses which included seizures, gastroparesis, and neuromuscular dysfunction of bladder. Resident #54's Quarterly Resident Assessment, dated 11/27/22, documented the resident required total assistance of one to two staff members for all ADL care. A Nursing Note, dated 12/23/22 at 9:21 a.m., read in part, resident has temp of 103; nurse practioner .called and message left on answering machine. A Nursing Note, dated 12/23/22 at 11:18 a.m., read in part, nurse practioner returned call and new order received for chest xray, cbc, cmp, rsv, and influzena [sic] stat; temp now 102.7. A Nursing note, dated 12/23/22 at 12:57 a.m., read in part, .new order received .rocephin 1 gram IM daily x 1 week, zithromax 250 mg daily for 1 week . On 01/09/22 at 2:45 p.m., the DON was asked when staff were to contact families. They stated with change of condition, and if sending resident to the hospital. The DON was asked if Resident #54's family had been notified of a change in condition. They stated, he was not, they specifically remembered the resident was running a temperature and the family member came to talk with me. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation the family had been made aware of the change in condition. 2. Resident #21 had diagnoses which included urinary tract infection. A Urinalysis and Culture results report, collection date 01/03/23, reported date 01/06/23, documented irregularities consistant with a UTI. Resident #21's January 2023 MAR, documented the resident received a new order on 01/10/23 for ertapenem sodium injection solution 1 gram for UTI for 7 days. On 01/10/23 at 9:25 a.m., LPN #7 was asked the reason Resident #21 was taking ertapenem. They stated they had received a verbal order on 01/03/23 to obtain a urine sample due to Resident #21 stating they thought they had a UTI. LPN #7 stated the results had been reported to the facility on [DATE]. The LPN was asked when the physician was notified, they stated on 01/09/23. On 01/10/23 at 09:40 a.m., LPN #7 was asked if labs had been followed up in a timely manner. They stated no, they didn't think so. LPN #7 stated the labs should be followed up on as soon as they were reported. LPN #7 stated the doctor was notified on 01/09/23. LPN #7 was asked if the physician was notified in a timely manner, they stated no. LPN #7 stated the physician should have been notified as soon as possible after the lab was reported.

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 On 01/06/23, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure policy was followed regarding allegations of misappropriation of pain medication signed out and not documented as given. On 01/03/23, LPN #1 signed out four narcotic pills for Resident #36, these were not documented as administered on the MAR. Upon interview, Resident #36 stated they did not receive any pain medications on 01/03/23. On 01/04/23, LPN #1 was observed signing out two doses of a narcotic pain medication when the count sheet for Resident #36 count was determined to be inaccurate during shift change. Resident #36 was not in the building at this time. LPN #1 returned to work on 01/04/23 despite the policy stating the employee would be suspended pending an investigation. LPN #1 signed out narcotics for Resident #54 fourteen times from 10/13/22 through 01/03/23 that were not documented as administered to the resident on the MAR. The potential for residents to go with untreated pain is present. The potential for drug diversion is present due to 16 controlled medications awaiting destruction were observed in the DON's office. There was no documentation the medication counts were verified when the medications were received by the DON from staff. There is no way of verifying what was currently awaiting destruction was what had been received. On 01/06/23 at 2:54 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 01/06/23 at 3:18 p.m., the DON and the ADON were notified of the IJ situation related to the facility's failure to ensure the facility policy was followed regarding allegations of misappropriation of controlled medication when narcotic pain medications had been signed out and not documented as given. The Administrator was not present at the time of the initial notification. On 01/06/23 at 7:20 p.m. a plan of removal was submitted to the Oklahoma State Department of Health. On 01/09/23 at 10:38 a.m., an acceptable plan of removal was accepted by the Oklahoma State Department of Health. The Plan of removal documented: Plan of Removal related to the noncompliance that has caused or is likely to cause serious injury, serious harm, serious impairment, or death. Inservice will be conducted on the regulation stating 2 signatures are required for all controlled medications that are DC'd from a patient's MAR or if a patient is discharged from facility. Nurse turning controlled medications over to DON and DON will count together remaining controlled medications and will both sign controlled medication count log. DON will then lock controlled medications in locked drawer and will remain in locked cabinet inside a closet with a keyed lock until destroyed with consulting pharmacist. That will put all controlled medications awaiting destruction behind 2 locked doors all the time and 3 locked doors when office is not occupied by DON and ADON. Complete RN pain assessment on all admitted residents/patients. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Inservice all employees on: 1. Signs and symptoms of pain 2. What to do if a patient/resident states they did not receive their pain medications. Inservice dated 01/06/23, no time, documented 62 staff members were in-serviced. It documented one staff member was on leave. Staff Inservice: Educated staff on the following: - Full Pain Assessment and follow-up - P.I.G. method - Properly documenting in EMAR at time of giving medication. - Misappropriation of resident/patient property (including all medications) and discipline action regarding a substantiated claim - General in-service regarding pain - Controlled medications for destruction must be counted with DON and signed by both parties. Resident/Patient Educated residents/patients on the following: - Full RN pain assessment completed on each resident/patient in facility - Interviewed each resident/patient (able to answer verbally) if they received medication when they asked for their medication - Asked if medication is effective when taken - Educated resident/patient how to report not getting PRN medication if they ask for it or not getting education in a timely manner - Pain interviews were completed and submitted for the 69 residents who remained in the facility. On 01/10/23 interviews were conducted with the nurses and medication aides across all shifts. The staff stated they had received in-service training related to misappropriation of medications and pain. The staff were able to identify what to do in the event a resident reported not receiving their pain medication. The facility completed audits on controlled medications awaiting destruction and ensured double signatures were in place verifying the count. Every resident in the facility was evaluated for pain. LPN #1 was suspended per Oklahoma State Reportable dated 01/09/23 at 2:47 p.m. On 01/10/23 at 8:27 a.m., the Administrator was notified the immediacy was lifted effective 01/06/23 at 7:30 p.m. The deficient practice remained at a potential for harm. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Based on record review, observation, and interview, the facility failed to ensure the abuse policy was followed regarding the following: A. Allegations of misappropriation of controlled pain medications were signed out and not documented as administered for three (#36, 38 and #54) of five sampled residents reviewed for pain, and B. Controlled medication count records were verified by two licensed nurses when removed from circulation and placed into the drawer for controlled medications awaiting destruction for 10 (#11, 36, 43, 48, 66, 70, 127, 128,129, and #130) of 11 sampled residents reviewed for controlled medications awaiting destruction. The Resident Census and Conditions of Residents report, dated 01/03/23, documented 71 residents resided in the facility. Findings: An Abuse Investigation and Reporting policy, revised 07/17, read in part, .All reports of resident abuse, neglect, exploitation, misappropriation of resident property .shall be promptly reported to local, state and federal agencies .and thoroughly investigated by facility management. Findings of abuse allegations will also be reported . If an incident or suspected incident of resident abuse .the Administrator will assign the investigation to an appropriate individual . The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation . The Administrator will ensure that any further potential abuse . is prevented . All alleged violations involving abuse .misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies . The State licensing/certification agency responsible for surveying/licensing the facility .The local/State Ombudsman .The Resident's Representative .Adult Protective Services .Law enforcement officials .The resident's Attending Physician .The facility Medical Director . An alleged violation of abuse .(including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than .Two (2) hours if the alleged violation involves abuse .or Twenty-four (24) hours if the alleged violation does not involve abuse . A Medication Storage in the Facility policy, effective date 04/18, read in part, .Medications included in the [agency name deleted] classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations . A controlled substance accountability record is prepared by the pharmacy/facility for all Schedule [two], [three], [four] and [five] medications . (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented . Any discrepancy in controlled substance counts is reported to the director of nursing immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies . If a major discrepancy or pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately . The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered . Controlled substance inventory is regularly reconciled to the Medication Administration Record . 1. Resident #36 had diagnoses which included End-Stage Renal Disease and depression. Resident #36's Care Plan, date initiated 12/11/22, documented the resident was at risk for pain with interventions which included administering analgesia as per orders. Resident #36's Five Day Resident Assessment, dated 12/15/22, documented Resident #36's cognition was intact. It documented there was no evidence of an acute change in mental status from the resident's baseline. The areas of inattention, disorganized thinking, and altered level of consciousness were all documented as behavior not present. It documented none of the above for potential indicators of psychosis. It documented Resident #36 received PRN pain medication or was offered and declined. It documented the resident did have pain present, occasionally and rated the pain at an eight on a zero-ten scale. Resident #36's Physician Order, dated 12/29/22, documented the resident was to receive oxycodone-acetaminophen oral tablet 10-325 mg one tablet by mouth every four hours as needed for pain. It documented to give with oxycodone/acetaminophen 5/325mg to equal 15mg. Resident #36's Controlled Drug Receipt/Record/Disposition form, date received 12/23/22, documented oxycodone/acetaminophen tab 10/325mg take one tablet by mouth every four hours as needed. It documented one pill was signed out on the following dates/times: 12/29/22 at 11:30 a.m., 12/30/22 at midnight, 12/30/22 at 4:00 a.m., 01/03/23 at 6:30 a.m., 01/03/23 at 6:06 p.m. and one on 01/04/23 at 6:30 a.m. Resident #36's Physician Order, dated 12/29/22, documented the resident was to receive oxycodone-acetaminophen oral tablet 5/325 mg give five mg by mouth every four hours as needed for pain. It documented to give with oxycodone/acetaminophen 10/325 to equal 15mg. Resident #36's Controlled Drug Receipt/Record/Disposition form, date received 12/27/22, documented oxycodone/acetaminophen 5/325mg take one tablet by mouth (take with 10mg to equal 15mg) every four hours as needed. It documented one pill was signed out on the following dates/times: 12/29/22 at 11:30 a.m., 12/30/22 at midnight, 12/30/22 at 4:00 a.m., 01/03/23 at 6:30 a.m., 01/03/23 at 6:06 p.m. and one on 01/04/23 at 6:30 a.m. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #36's December 2022 MAR/TAR did not document the above medications had been administered to the resident. Resident #36's January 2023 MAR/TAR did not document the above medications had been administered to the resident. LPN #1's Employee Daily Punch Report, dated 01/03/23, documented a clock in time of 3:34 p.m. and a clock out time of 8:39 a.m. LPN #1's Employee Daily Punch Report, dated 01/04/23, documented a clock in time of 3:45 p.m. and a clock out time of 8:50 a.m. LPN #1 was not suspended per policy. An Employee Disciplinary Form for LPN #1, dated 01/04/23, read in part, .Employer Statement: Employee failed to document PRN med given in [electronic record system], and properly signed out on Narc at the time it was given . Actions for employee to correct: Employee will be in serviced on punch, initial, given method as well documentation. Employee will be put on PIP . Resident #36's State Reportable, transmission date 01/05/23 at 10:26 a.m., documented the incident report form was a Combined Initial and Final. It documented an investigation for misappropriation of resident property was conducted involving Resident #36 and LPN #1. It documented the incident date was 01/04/23. It documented description of incident: Percocet 10/325mg x1 and Percocet 5/325mg x1 documented on narcotic count log at 6:30 a.m. on 01/04/2023. Resident #36 was out of the facility at dialysis at the documented time. There was no documentation in the Please Include relevant resident history section. In Part C' of the report, it documented the facility interviewed Resident #36 at the time of returning to the facility. Resident stated that he received both percocet pills at 4:30 a.m. prior to leaving facility for dialysis. It documented the staff spoke with LPN #1 who admitted writing down the wrong administration time. It documented LPN #1 was educated and inserviced on using proper P.I.G. method for giving medications. It documented LPN #1 was given a final write up. It documented three residents who received PRN narcotics were interviewed and all stated they received their narcotics when they asked for them during this LPN's shift. It documented no misappropriation of resident's medication had been substantiated. It documented all allegations have been found to be unsubstantiated during the investigation. It documented all narcotics were accounted for. The facility failed to implement their Abuse Investigation and Reporting policy by failing to report an alleged violation of abuse within two hours per their policy. The report had not been filed within 24 hours of the DON being made aware of the alleged misappropriation of a controlled substance involving Resident #36 and LPN #1. The State reportable also failed to address the DON's conversation where Resident #36 reported to the DON they did not receive any pain medication on 01/03/23 and LPN #1 signed out two oxycodone 10/325mg and two oxycodone 5/325mg and did not document the medications as administered to Resident #36 on 01/03/23. LPN #1's Employee Daily Punch Report, dated 01/05/23, documented a clock in time of 3:12 p.m. and a clock out time of 8:21 a.m. LPN #1 was not suspended per policy. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #36's State Reportable, transmission date 01/06/23 at 7:53 p.m., documented the same front page State Reportable as above, except the Combined Initial and Final was marked through and Initial was selected. The words Initial Incident Report only .wrong box checked. This was signed by the DON. The facility failed to implement their Abuse Investigation and Reporting policy by failing to immediately suspending the employee who had been accused of resident misappropriation pending the outcome of the investigation and ensuring that any further potential abuse, neglect, exploitation or mistreatment was prevented. LPN #1 worked a double shift on 01/04/23 and 01/05/23 prior to the abuse investigation being complete. Resident #36's State Reportable, transmission date 01/09/23 at 2:47 p.m., documented Follow up Info with relevant resident history: Resident receives medication when asked. Resident stated they received medication prior to leaving for dialysis. No additional information related to the resident's medical history, cognitive status or diagnoses was included. It documented follow up information: Upon further Investigation of auditing narcotic sheets to EMAR, found discrepancies between the two. It documented the LPN was suspended for ongoing investigation, notified LPN Licensing Board. The Complaint Form attached to the State Reportable for Resident #36, dated 01/09/23 at 9:03 a.m., read in part, .[Nursing Board Name Deleted] .Nurse's Name: [LPN #1] .Please specify the length of time the nurse worked in your location .More than five years . Description of Incident: Nurse signed out narcotic at [7:00 a.m.] for a late documentation for a dose given at [6:30 a.m.] on 01/04/23 for [Resident #36] and admitted to another person that [they] gave [error] did in fact give dose at that time. {Resident #36] was not in facility at [6:30 a.m.], as [they] leave for dialysis at [4:30 a.m.] on MWF. Dose of narcotic was also not documented in EMAR. After investigation, there is a pattern with other residents narcotics being signed out but not documented in the EMAR . Did incident include Misconduct or Criminal Behavior .Yes: Theft (including drug diversion) .Did incident result in Patient Harm .Harm- An error occurred which caused a minor negative change in the patient's condition . The report was filled out by the DON. None of the above State Resportables documented Resident #36's family or legal representative was notified per facility policy. None of the above State Reportables documented the Ombudsman, Adult Protective Services, or Law inforcement officials were contacted per the facility Abuse Investigation and Reporting policy. On 01/04/23 at 6:28 a.m., LPN #1 was observed responding to a call light in room [ROOM NUMBER]. LPN #1 remained in the surveyor's line of sight from 6:28 a.m. through 7:20 a.m. On 01/04/23 at 7:20 a.m., LPN #1 was observed conducting a count of the controlled medications located on their medication cart with LPN #3. When they came to Resident #36's oxycodone/acetaminophen 10/325mg, LPN#1, who was reviewing the count book called out, 19, LPN #3 who was looking at the carded controlled medications on the cart, called out, 18. LPN #1 was observed signing out one pill on the count sheet and documented the time as 6:30 a.m. and changed to count to 18. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Both nurses continued on with the count. The next card for Resident #36 was oxycodone/acetaminophen 5/325mg, LPN #1, who was reviewing the count book called out, 50. LPN #3 who was looking at the carded controlled medication called out, 49. Again, LPN #1 was observed signing out one pill and documented the time at 6:30 a.m. and changed the count to 49. LPN #1 was asked to explain signing out these meds for the time of 6:30 a.m. They stated, That's when I gave it. LPN #1 was asked to explain the reason they signed out both medications when the count was noted to be wrong. They stated, I forgot to sign it out. They stated, That's all I can tell you. LPN #1 was asked the policy for administering controlled medications. They stated, Punch, sign, give. They stated, That's how we're supposed to do it. Both LPN #1 and LPN#3 failed to follow the Medication Storage in the Facility policy because they failed to immediately report any discrepancy in controlled substance counts to the DON. LPN#1 was not observed administering any medications during the documented time. On 01/04/23 at 9:04 a.m., the DON was asked if Resident #36 had left the facility. She stated the resident had left for dialysis. She stated Resident #36 had left around 4:15 a.m. She was asked what the facility policy was for ensuring resident medications were not misappropriated. She stated staff counted before and after every shift. She was asked if LPN #1 had left for the day. She stated, Yes, I think so. The DON stated, if the count was wrong, no one would leave the shift. She stated staff should report it to the DON and nobody would leave until the count was resolved. She stated they would conduct an investigation. The DON stated, if they could not determine where the medication count was wrong, the staff would be sent home, law enforcement would be notified, and a full investigation would be completed. The DON stated whatever staff member was involved when it went missing, would immediately be placed on suspension, pending the investigation. She stated if she was not at the facility, staff were to notify the ADON and the Administrator had to be notified. She stated staff could not leave until someone was there to investigate. The DON was asked what the policy was for administering controlled substances to residents. She stated staff were to assess the resident first, check orders, administer the correct pain medication for the pain level, verify the count, sign it out on the count log, and document it was administered in the electronic medical record. She stated, It all should be done in real time. She was asked if staff counted off controlled substances at shift change. She stated, Yes. The DON was asked to review Resident #36's January 2023 MAR/TAR and identify the last time the resident received oxycodone 10-325mg. She stated, Monday the second at 4:45 in the morning. She was asked when Resident #36 last received their oxycodone 5/325mg. She stated, Sunday the first at [1:58 p.m.]. The DON was asked to review the count sheet for Resident #36's oxycodone 5/325mg. She was asked if one tablet was signed out at 6:30 a.m. on 01/03/23. She stated, Yes. She was asked if one tablet was signed out at 6:06 p.m. on 01/03/23. She stated, Yes ma'am. She was asked if one tablet was signed out at 6:30 a.m. on 01/04/23. She stated, Yes ma'am. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON was asked who signed these medications out. She stated, Looks like LPN #1. She was asked to review the count sheet for oxycodone 10/325mg. She was asked if it documented one tablet was signed out at 6:30 a.m. and one tablet at 6:06 p.m. on 01/03/23, and one tablet signed out at 6:30 a.m. on 01/04/23. She stated, Yes. She was asked who signed the medications out. She stated, Looks like LPN #1. The DON then verified none of the doses were documented as administered in the resident's MAR/TAR. The DON was made aware of the above observations involving the narcotic count during shift change with LPN #1 and LPN #3. She was made aware LPN #1 was in direct view of the surveyor during the time she signed out the medications. The DON was asked if Resident #36's medication was misappropriated as it was signed out and not documented as given during the time LPN #1 was observed by the surveyor to not be administering medication and the resident being gone to dialysis during that time. The DON stated Resident #36 Wasn't even in the building. She stated she would conduct an investigation/State Reportable. On 01/04/23 at 9:32 a.m., the DON provided a note which documented a transport company name and the time of 4:30 a.m The DON stated Resident #36 had been picked up by the driver whose name was on the note, the company who picked them up, and the time was 4:30 today [01/04/23]. On 01/04/23 at 10:34 a.m., the DON sated she had started an investigation for the medication. She stated Resident #36 had returned from dialysis. On 01/04/23 at 10:40 a.m. the DON reported Resident #36 definitely received two pills today but the time was inaccurate. She stated for the 6:30 a.m. and 6:06 p.m. doses on 01/03/23, the resident did not get those pills. She stated the resident reported they only take those pain medications if they get out of bed or go to dialysis. The DON stated they were continuing their investigation. On 01/04/23 at 11:07 a.m., Resident #36 was asked if they received any pain medication for the day. They stated they did receive both the 10mg and 5mg of oxycodone before leaving for dialysis. They were asked if they received any pain medications yesterday, 01/03/23. They stated they did not take any pain pills yesterday. They stated they only took them when they went to dialysis or when they got up. On 01/04/23 at 6:45 p.m., the DON was asked if there was an update on the investigation. The DON stated they talked to Resident #36 and was informed by the resident the morning dose was received. She stated Resident #36 stated they had not received pain medication yesterday, 01/03/23. The DON stated LPN#1 had been interviewed and showed her a detailed note book paper they kept. She stated the note book paper had different notations of residents she had given medications to. The DON stated they notified the Administrator and was informed by the Administrator it was missed documentation. The DON stated, He said to not suspend [LPN #1] against my better judgement. She stated, After my full investigation [LPN#1] was in-serviced on the importance of documentation and late entry in our [eMAR]. The DON was asked what she meant by against her better judgement. The DON did not reply. The DON was asked for a copy of the investigation. The DON stated, I can get one together. (continued on next page)

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Sienna Extended Care & Rehab	9221 Harmony Drive Midwest City, OK 73130

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	01/04/23 at 7:00 p.m., the Administrator stated, I don't know what you talking about missing meds. He stated, It's a documentation error. It is in there now. The Administrator was informed of the allegation of misappropriation that was reported to the DON. The Administrator stated the Resident #36 was forgetful and confused and was in the nursing home because of deficits. The Administrator asked, Do you know the resident's BIMS [cognition]. The Administrator was informed Resident #36's cognition was intact per the medical records. The Administrator was asked if an investigation should be conducted for an allegation of misappropriation. The Administrator stated, LPN #1 probably worked 16 hours and was tired. On 01/04/23 at 7:15 p.m., the DON provided copies of two hand written notes titled Investigation, dated 01/04/23, documented Resident #36 had reported receiving pain medication before dialysis on 01/04/23. It documented the time was inaccurate. It documented LPN #1 was out of the building for eight hours, the abuse investigation was complete. The DON and ADON signed the form. An untitled and undated in-service sheet with LPN #1's name printed with signature was received. A 22-page document, titled Institutional Drug Diversion presented by a consultant Consultant Pharmacist dated January 4 2023 was received. On 01/09/23 at 8:00 a.m., the DON was asked if Resident #36's narcotic count sheet documented one oxycodone 5/325 was signed out on 12/28/22 at 11:30 a.m. She stated, Yes. She was asked if the December MAR/TAR documented the medication was administered to the resident. She stated, I don't see that one. She was asked if the narcotic count sheet documented one oxycodone 5/325 was signed out on 12/30/22 at midnight and one at 4:00 a.m. She stated, Yes. The DON was asked if the same nurse signed out all three. She stated it looked like [LPN#2] signed out all three. She was asked if the resident's MAR/TAR documented the medications were administered to the resident. She stated, I don't see those as well. The DON was asked if Resident #36's narcotic count sheet for oxycodone 10/325mg documented one pill was signed out by the same nurse on 12/29/22 at 11:30 a.m., 12/30/22 at midnight, and 12/30/22 at 4:00 a.m. She stated, Yes. She was asked if the December 2022 MAR/TAR documented these medications were administered to the resident. She stated, I don't see them. On 01/09/23 at 8:48 a.m. the administrator provided copies of the state reportable dates 01/05/23 at 10:26 a.m. he explained the DON mismarked the incident report combined initial and final. He stated the facility resubmitted the incident as an Initial on 01/06/23 at 7:53 p.m. This was after the IJ was announced. He stated the investigation was ongoing because he had five days. 2. Resident #38 had diagnoses which included type two Diabetes Mellitus, lymphoma, major depressive disorder and pressure ulcer left heel. Resident #38's Physician Order, dated 05/26/22, documented Percocet 10/325 (oxycodone/acetaminophen) one tablet by mouth every four hours as needed for pain. Resident #38's Annual Resident Assessment, dated 12/18/22, documented the resident's cognition was intact, the resident received scheduled pain medication, was offered or received PRN pain medication and the resident had no pain present during the past five days. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #38's Controlled Drug Receipt/Record/Disposition form, date received 12/16/22, documented oxycodone/acetaminophen 10/325 mg take one tablet by mouth every four hours as needed. It documented one pill was signed out on the following dates/times: 12/20/22 at 6:00 p.m., 12/21/22 at 5:30 p.m., 12/22/22 at 9:00 p.m., 12/23/22 at 1:30 a.m., 12/24/22 at 7:00 a.m., 12/27/22 at 5:53 p.m., 12/28/22 at 7:30 p.m., 12/29/22 at 6:30 a.m., 12/29/22 at 7:40 p.m., 12/30/22 at 3:00 a.m., 12/30/22 at 8:33 a.m., 12/30/22 at 7:00 p.m., 01/02/23 at 6:00 p.m., and 01/03/23 at 5:00 p.m. Resident #38's December 2022 and January 2023 MAR/TAR did not document the above oxycodone/acetaminophen 10/325 were administered to the resident. On 01/09/23 at 12:57 p.m. the DON was interviewed, the Administrator was present during the interview. The DON was asked if Resident #38's narcotic count sheet documented one oxycodone 10/325mg was signed out on 01/02/23 at 6:00 p.m. She stated, Yes. She was asked if there was documentation this medication was administered to the resident on the MAR/TAR. She stated, There's not one documented on 01/02. The DON was asked if the narcotic count sheet documented one oxycodone 10/325mg was signed out on 01/03/23 at 5:00 p.m. She acknowledged it did. She was asked if there was documentation the medication was administered to the resident on the MAR/TAR. She stated, No ma'am. She was asked who signed out the medication. She stated it looked like LPN #1. The DON was asked to review Resident #38's count sheet and identify if one oxycodone 10/325mg was signed out at 3:00 a.m., 8:33 a.m. and 7:00 p.m. on 12/30/22 at 8:33 a.m., 6:30 a.m. and 7:40 p.m. on 12/29/22, 7:30 p.m. on 12/28/22, 5:53 p.m. on 12/27/22, 7:00 a.m. on 12/24/22, 1:30 a.m. on 12/23/22, 9:00 p.m. on 12/22/22, 5:30 p.m. on 12/21/22 and 6:00 p.m. on 12/20/22. She stated yes to all. She was asked if any of these medications were documented as administered on the resident's MAR/TAR. She stated, No. She was asked if the same nurse signed out all of these medications except the dose on 12/30/22 at 8:33 a.m. She stated, Yes. She was asked if she could identify who signed the medications out. She stated, LPN #1. 3. Resident #54 had diagnoses which included pain. Resident #54's Care Plan, revised 03/21/22 documented the resident had a risk for pain. Resident #54's Controlled Drug Receipt form, date received 10/07/22, documented on 10/13 the APAP/Codeine tab 300-30mg (Tylenol with Codeine #3) was signed out two different times. It documented 10/17/22, 10/18/22, 11/03/22, 11/17/22, 12/12/22, 12/15/22, 12/23/22, 12/26/22, 12/27/22, 12/29/22, 12/30/22, and 01/03/23 it was signed out one time each day. Resident #54's October 2022 MAR did not document the Resident had received the Tylenol with Codeine on 10/13/22, 10/17/22, and 10/18/22. Resident #54's November 2022 MAR did not document the Resident had received the Tylenol with Codeine on 11/03/22 and 11/17/22. Resident #54's December 2022 MAR did not document the Resident had received the Tylenol with Codeine on 12/12/22, 12/15/22, 12/23/22, 12/26/22 12/27/22, 12/29/22, and 12/30/22. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #54's January 2023 MAR did not document the Resident had received the Tylenol with Codeine on 01/03/23. On 01/06/23 at 11:55 a.m., the DON was asked to identify when Resident #54's Tylenol with Codeine had been signed out on the control drug sheet. She stated it had been signed out on 10/13/22, 10/17/22, 10/18/22, 11/03/22, 11/17/22, 12/12/22, 12/15/22, 12/23/22, 12/26/22, 12/27/22, 12/29/22, 12/30/22, and 01/03/23. They were asked to review Resident #54's MARs for October, November, December, and January. They stated no, it does not appear that they received Tylenol with Codeine on those dates. The DON was asked to identify the signature on the controlled drug receipt for the Tylenol with Codeine, they stated it was LPN # 1. 4. On 01/05/23 at 3:10 p.m., The DON was observed removing controlled medications awaiting destruction from the top drawer of a file cabinet located in the closet in the DON's office. She was asked to explain the process for when a controlled medication was discontinued or the resident discharged . She stated there would be a discontinue order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35389 Based on observation, record review, and interviews the facility failed to: A. Provide baths/showers to dependent residents for four (#10, 31, 38, and #54), B. Provide incontinent care in a timely manner for one (#11) and, C. Provide nail care for one (#58) of nine sampled residents reviewed for ADLs. The Resident Census and Conditions of Residents report, dated 01/03/23, documented 71 residents resided in the facility. Findings: A Shower/Tub Bath policy, revised October 2010, read in part, .The following information should be recorded on the resident's ADL record and/or in the resident's medical record .The date and time the shower/tub bath was performed .If the resident refused the shower/tub bath, the reason(s) why and the intervention taken . Notify the supervisor if the resident refuses the shower/tub bath . A Care of Fingernails/Toenails policy, revised 10/10, read in part, .Nail care includes daily cleaning and regular trimming .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease . 1. Resident #10 had diagnoses which included fracture of upper and lower end of right fibula. An Admission Resident Assessment, dated 12/09/22, documented Resident #10's cognition was intact and they required extensive assistance with bathing. On 01/03/23 at 9:42 a.m., Resident #10 was asked if they received baths as scheduled. They replied, No,I haven't had a bed bath in over a week and I feel nasty. A Bathing Task sheet, reviewed on 01/10/23, read in part, .Bathing .Tues-Thurs-Sat on 3-11 .No Data Found . No bathing records were found for the thirty day look back period. On 01/09/23 at 2:44 p.m., the wound care nurse was shown the bathing task and was asked if Resident #10 had been bathed per schedule. They stated there was no documentation to show that bathing had been provided. 2. Resident #31 had diagnoses which included cellulitis of the right upper limb. A Resident Assessment, dated 11/08/22, documented Resident #31's cognition was intact and they required limited assistance for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/04/23 at 10:08 a.m., Resident #31 was asked if they received their baths as scheduled. They stated they missed a bath at least once a week. A Bathing Task, reviewed for the past 30 days, documented Resident #31 was scheduled to be bathed on Mondays, Wednesdays, and Fridays. The task documented Resident #31 had not been bathed nine out of the 13 scheduled days. On 01/09/23 at 2:46 p.m., the wound care nurse was shown Resident #31's bathing task and was asked if they had been bathed as scheduled. They stated they did not have documentation to show Resident #31 had been bathed as scheduled. 3. Resident #38 had diagnoses which included ESRD, obesity, pressure ulcer of left heel and fatigue. Resident #38's Annual Resident Assessment, dated 12/18/22, documented bathing did not occur over the past seven days. Resident #38's Care Plan, revised 09/23/22, documented interventions which included to provide a sponge bath when a full bath or shower cannot be tolerated. Resident #38's bathing records documented the resident was to receive bathing on Tuesday, Thursday, and Saturday. The record documented the resident received bathing assistance on 12/20/22, 12/29/22, 01/03/23 and 01/05/23. There was no documentation Resident #38 was bathed nine out of 13 opportunities in the past 30 days. On 01/03/23 at 10:51 a.m., Resident #38 was asked if they received bathing assistance as often as they would like. They stated they wanted to be bathed twice a week, but they only received a bath once a week. Resident #38 stated they sometimes only received a bath once every other week. The resident's hair was observed to be greasy in appearance. On 01/09/23 at 1:26 p.m., the wound care nurse, who the DON identified as the person responsible for overseeing the bathing of residents, was asked who was responsible for overseeing the residents' baths. They stated everyone actively worked on making sure residents received showers. They stated the charge nurse needed to oversee aides to ensure bathing records were completed. They stated the 11:00 p.m. to 7:00 a.m. shift was responsible for PRN showers. The wound care nurse stated they collected the forms and placed them in a book. The wound care nurse was asked how staff documented a resident was bathed. They stated staff documented in the ADL electronic record system and they also had their shower forms. They were asked what days Resident #38 was scheduled to be bathed. They stated the resident was to be bathed on Tuesday, Thursday and Saturday. The wound care nurse was informed of the above bathing documentation and was asked to provide documentation the resident received bathing per schedule. On 01/10/23 at 7:16 a.m., the wound care nurse was asked if they located any additional information Resident #38 received their bath/shower as scheduled. They stated, I did not. 4. Resident #54 had diagnoses which included seizures, gastroparesis, and neuromuscular dysfunction of bladder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Resident Assessment, dated 11/27/22, documented Resident #54 required total assistance of one to two staff members for all ADL care. An ADL bathing task for December and January 2023, documented, Resident #54 had not received baths for three of 12 opportunities for a bath to be provided. On 01/10/23 at 10:45 a.m., the wound care nurse was asked what Resident #54's bath schedule was. They stated Monday, Wednesday, and Friday on the 7-3 shift. After reviewing the bathing task, the wound care nurse stated Resident #54 did not receive baths on 12/14/22, 12/16/22, and 12/19/22. 35749 42024 5. Resident #11 had diagnoses which include atrial fibrillation, chronic pain, seizures, anxiety, major depressive disorder, myocardial infarction, unsteadiness on feet, history of falling and physical debility. Resident #11's discharge return anticipated assessment, dated 12/23/22, documented the resident's cognition was severely impaired, and they required extensive to total assistance of one to two staff members for all ADL care. The assessment documented the resident was incontinent of bowel and bladder. On 01/03/23 at 11:23 a.m., Resident #11 was observed in bed with the head of the bed up 30 degrees. The oxygen concentrator was on at 4L and nasal cannula was on the floor between the concentrator and bed. The resident was observed moving left leg off pillow and a large brown stain was observed on the white fitted sheet and pillow case. Resident #11 was asked what the stain on the sheet and pillow case was. The resident stated, I guess it is urine stain. The resident stated, I had not been changed since last night, and not for today yet. On 01/03/23 at 11:54 a.m., CNA #6 was asked if they were assigned to Resident #11. CNA #6 stated they were assigned to hall 200 and had room [ROOM NUMBER] and 301. CNA #6 stated CNA #7 was assigned to the remaining resident on 300 and CNA #6 was helping CNA #7 where needed. CNA #7 was observed assisting a resident out of the shower room and was asked who was assigned to Resident #11. CNA #7 stated they were the staffing coordinator and both they and CNA #6 were assigned to Resident #11. CNA #7 was asked when was the last time Resident #11 was checked and changed. CNA #7 stated I can't tell you the last time Resident #11 was cleaned up, but was checked around 10:00 a.m. On 01/03/23 at 12:00 p.m., CNA #6 and CNA #7 were asked to accompany this surveyor to check Resident #11. CNA #6 and CNA #7 entered the room, Resident #11 stated I have been wet and had not been changed. CNA #6 and CNA #7 acknowledge that the brown ring under the resident was a urine stain. Both CNAs acknowledge they had not provided incontinent care to resident since the start of their shift. 46216 6. Resident #58 had diagnoses which included diabetes mellitus, lack of coordination and morbid obesity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #58's Care Plan, revised 08/26/22, documented the resident had an ADL self-deficit related to impaired balance and limited mobility. It documented interventions which included check nail length and trim and clean on bath day and as necessary. It documented to report any changes to the nurse. Resident #58's Quarterly Resident Assessment, dated 11/15/22, documented the Resident's cognition was intact and required extensive two person physical assistance for the task of personal hygiene. On 01/04/23 at 9:52 a.m., Resident #58 was observed to have nails which hung over their fingertips approximately 1/2 inch. The nails were observed to have a yellow/orange color to them. The Resident was asked if staff trimmed their nails or cared for their nails when needed. They stated, No. They were asked if they would like their nails to be trimmed. They stated, Yeah. On 01/10/23 at 2:40 p.m., CNA #1 was asked if they was familiar with Resident #58. They stated, Yes. They were asked if they provided personal care to the resident. They stated, Yes. They were asked what type of nail care they provided to residents. They stated nail clipping, cleaning under nails, shaping nails and washing hands if the resident needed help. CNA #1 was asked how they determined when nails needed to be trimmed. They stated, When they are getting a little long. CNA #1 was asked to observe Resident #58's nails. They walked into the resident's room. After exiting the room, CNA #1 was asked if the Resident #11's nails appeared clean and well trimmed. They stated, No. They were asked if they could identify the last time the resident's nails were cleaned or trimmed. They stated, I don't know.

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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. 41318 Based on record review and interview, the facility failed to ensure neuro checks and post fall assessments were completed for one (#41) of one sampled residents reviewed for falls. The Resident Census and Conditions of Residents report, dated 01/03/23, documented 71 residents resided in the facility. Findings: The facility's Neurological Assessment policy, revised October 2010, read in parts, .Neurological assessments are indicated .Following an unwitnessed fall . The facility's Assessing Falls policy, revised October 2010, read in parts, .Nursing staff will observe for delayed complications of a fall for approximately forty-eight .hours after an observed or suspected fall, and will document findings in the medical record . Resident #41 had diagnoses of unsteadiness on their feet, lack of coordination, weakness, and unspecified fall. Resident #41's Care Plan, revised 12/03/21, documented the resident was at risk for falls related to gait/balance problems, and decreased safety awareness. It documented for staff to follow the facility's fall protocol. Resident #41's quarterly assessment, dated 10/16/22, documented the resident's cognition was intact, and they required extensive staff assistance with bed mobility and transfers. Resident #41's Incident Note, dated 11/28/22, read in parts, .Nurse notified by PT that resident was found on floor beside bed . There was no documentation in the resident's clinical health record the resident was assessed post fall, or neuro checks were completed for the unwitnessed fall on 11/28/22. Resident #41's Incident Note, dated 01/04/23, read in parts, .Res observed laying on the floor next to [their] bed . On 01/04/23, there was no documentation in the resident's clinical health record the resident was assessed post fall, or neuro checks were completed for the unwitnessed fall. On 01/10/23 at 10:30 a.m., the DON stated neuro checks were completed, on a neuro check sheet, after an unwitnessed fall. The DON stated the neuro check sheet would be uploaded to the resident's EHR. The DON stated falls were documented in the incident note and incident report. The DON stated the resident would be monitored for 72 hours after fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/23 at 10:37 a.m., the ADON was asked if they would locate the post fall assessments and neuro checks for Resident #41's fall documented on 11/28/22. The ADON was observed looking in the EHR. They stated they were only able to locate the initial assessment of the fall. They stated they did not locate any neuro checks for the fall on 11/28/22. The ADON was asked if they could locate the post fall assessments and neuro checks for the fall documented on 01/04/23. They stated they didn't see anything.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42024 Based on record review, observation and interview, the facility failed to ensure: a. Thorough skin assessment was conducted on readmission, b. Weekly skin monitoring and/or weekly wound assessments were conducted, c. The physician was notified timely of the new or worsening wound; and d. Adequate wound care/treatment was initiated timely for one (#11) of three sampled residents reviewed for pressure ulcers. This resulted in actual harm to Resident #11 who developed a pressure injury which worsened to an avoidable pressure injury with slough visible. The DON identified 71 residents who were at risk for skin breakdown. Findings: The facility's Wound Care policy, revised October 2010, read in parts, The purpose .is to provide guidelines for the care of wounds to promote healing .Verify that there is a physician's order .Review the resident's care plan to assess for any special needs of the resident .The following information should be recorded in the resident's medical record .The type of wound care given .any changes in the resident's condition All assessment data .Report other information in accordance with facility policy and professional standards of practice. Resident #11 had diagnoses which include atrial fibrillation, chronic pain, seizures, obstructive sleep apnea, osteoporosis, hypertension, prostatic hyperplasia, muscle spasms, myocardial infarction, unsteadiness on feet, history of falling and physical debility. Resident #11's Care Plan, revised 11/28/22, documented the resident had impaired skin integrity with redness to abdomen folds, buttocks, groin and legs recurrent. Interventions to include document any abnormalities found, obtain appropriate treatment. Monitor skin weekly by charge nurse. Weekly skin assessments every Wednesday 7-3 shift. The care plan documented the resident has potential for pressure ulcer development. Interventions to include follow facility policies/protocols for the prevention/treatment of skin breakdown, frequent repositioning and consult with wound nurse on admit and as needed. Monitor/document and report any changes in skin status. Use draw sheet or lifting device to move resident. A Physician's Order, dated 12/5/22, documented to apply wound dressing external cream to buttocks topically every shift for discoloration. A Physician's Order, dated 12/21/22, documented to apply wound dressing external gel to left buttock topically every shift for skin scrape. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #11's discharge return anticipated assessment, dated 12/23/22, documented the resident's cognition was severely impaired, and they required extensive to total assistance of one to two staff members for all ADL care. The assessment documented resident was incontinent of bowel and bladder and had no skin concerns. Resident #11 readmitted to facility the on 01/01/23 after an eight day stay in hospital. A Progress Note, dated 01/01/23, read in part, Late Entry Resident return to facility alert and oriented x4, delivered by transporter in w/c. DX. UTI continue orders with orders noted. Scrotum swelling with open area to right buttocks and left thigh. There was no documentation the physician was notified of open area to right buttock and left thigh. There was no documentation of a treatment in place for open area to right buttock and to left thigh. There was no documentation admission assessments were completed upon Resident's #11 readmission to facility. There was no documentation a thorough skin evaluation was completed upon readmission. On 01/03/23 at 12:03 p.m., Resident #11 was observed during incontinent care provided by CNA #6 and CNA #7. A dime sized open area was observed to Resident #11's right upper buttock near the coccyx. A one-inch skin tear was observed with partial flap loss, and a red wound bed located to the left lower buttock closer to left thigh (gluteal fold). CNA #7 stated while wiping resident's buttocks, I need to tell wound nurse about tear on bottom. A Physician's Order, dated 01/03/23, documented to leave tabs open on brief every shift for scrotal edema. A Physician's Order, dated 01/03/23, documented to give Lasix 40 MG by mouth two times a day for edema. A Braden Scale for Predicting Pressure Ulcer Risk, dated 01/06/23, documented a score of 22 (No Risk). The document stated the resident had no impairment in sensory perception, rarely moist (skin is usually dry), walks frequently, had no limitation with mobility, nutrition adequate and no apparent problem with friction and shear. A Skin Only Evaluation, dated 01/06/23, documented, the resident had no current skin issues. On 01/10/23 at 10:16 a.m., LPN #5 was asked what was the protocol when there was a resident admitted or readmitted to the facility. LPN #5 stated the resident would be assessed, vitals taken, a complete skin assessment and review medications with physician. LPN #5 was asked what skin concerns did Resident #11 have. LPN #5 stated Resident #11 had no skin concerns that was reported and none had been seen in the chart. LPN #5 stated they had not seen the resident since the shift started. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/10/23 at 10:21 a.m., the DON was interviewed, the Administrator was present during the interview. The DON was asked what was the facility's protocol when a resident admitted or readmitted . The administrator stated, We go through the admission process whether it is an admit or readmit. He stated the staff were expected to follow the admission check list. The administrator asked the DON to retrieve a copy of the check list. The administrator stated the nurses had the check list. The administrator stated, The challenge is the lack of staff and use of agency. The administrator stated the DON and MDS coordinator would monitor what was done or incomplete for the admission/readmission. On 01/10/23 at 10:35 a.m., the administrator was asked to show the documentation where Resident's #11 readmission assessment was completed. The administrator stated, I will need to go look and will let you know. On 01/10/23 at 10:41 a.m., the Administrator provided a copy of a Skin Only Evaluation, dated 01/06/23 which documented No skin issues noted. The administrator stated, Readmission was not completed. On 01/10/23 at 11:35 a.m., the wound care nurse was asked what skin changes were currently being treated for Resident #11. The wound care nurse stated the resident returned from the hospital with scrotal edema and was currently being addressed with medication and scrotal cradle. The wound care nurse stated, It has improved by reduction in size. The wound care nurse was asked how often were skin assessments completed. The wound care nurse stated skin assessment were completed on admission/re-admission, weekly and as needed. The wound care nurse was asked if Resident #11 had any other skin concerns or changes. The wound care nurse reviewed the resident's EMAR and stated the resident had been getting Triad wound external cream since December for discoloration to buttocks. They stated, I do not know what the wound external gel is for, that left buttock skin tear was not on my radar. On 01/10/23 at 11:46 a.m., the wound care nurse was asked to accompany this surveyor to assess Resident's #11 skin. On 01/10/23 at 11:49 a.m., the wound care nurse and this surveyor entered Resident #11's room. The resident was informed by wound care nurse that they needed to conduct a full body skin assessment and Resident #11 agreed. They assessed the resident for pain, performed hand hygiene, donned gloves and proceeded to assist the resident with turning. The resident was turned to the left side, the wound care nurse removed white thick cream that was present on the resident's buttocks and coccyx. They measured the area and stated, small open area to right buttocks 0.2 cm by 6 cm by 0.1 cm. They observed an area to the right lower abdomen. The wound care nurse stated, I don't know what this is 2.1 cm. The wound care nurse observed a 4x4 adhesive border dressing on the left thigh (gluteal fold). The dressing was observed with discoloration visible from outside the dressing. They were observed removing dressing and stated I was not notified; I am sad and mad. They assessed the resident for pain and the resident denied. They described the area as 2.2 cm by 3 cm by 0.1 cm wound bed 50/50 slough and granulation with small amount of purple (half of a pencil eraser). They stated, The peri wound is normal pallor. They stated, I will notify my wound doctor. They stated, The wound doctor stages. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/10/23 at 12:12 p.m., the wound care nurse was informed the wound to the left thigh (gluteal fold) had worsened significantly since the observation made on 01/03/23. The wound nurse acknowledge that the wound had worsened, there was no treatment in place, the physician had not been notified, and no skin assessment had been completed on 01/01/23 when the resident readmitted .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 35389 Based on record review, observation, and interview, the facility failed to ensure: A. coordination of care with a third party dialysis center, B. weights obtained as ordered, and C. a resident was assessed after returning from dialysis for one (#38) of one sampled resident reviewed for dialysis services. The Resident Census and Conditions of Residents report, dated 01/03/23, documented five residents received dialysis services. Findings: A Weight Assessment and Intervention policy, revised 09/08, read in part, .Weights will be recorded in each unit's Weight Record chart or notebook and in the individual's medical record . An End-Stage Renal Disease, Care of a Resident With policy, revised 09/08, read in part, .Residents with . ESRD .will be cared for according to currently recognized standards of care .Education and training staff includes .The type of assessment data that is to be gathered about the resident's condition as needed . Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including .How information will be exchanged between the facilities . Resident #38 had diagnoses which included ESRD. A Physician Order, dated 12/14/20, documented the resident was to receive dialysis three times weekly on an out patient basis MWF at 10:00 a.m. Resident #38's most recent Hemodialysis Communication Form was dated 11/20/21. A Physician Order, dated 04/29/22, documented to obtain weekly weights every Monday, Wednesday and Friday related to ESRD. It documented weights were needed before dialysis. A Care Plan, revised 09/23/22, documented the resident needed hemodialysis. It documented interventions which included check and change dressing at access site daily, document, and dialysis three times weekly on MWF at 10:00 a.m. An Annual Resident Assessment, dated 12/18/22, documented the resident's cognition was intact and they received dialysis services while a resident. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2022 MAR/TAR failed to document staff were checking/changing dialysis access cite dressing daily per plan of care. There was no documenation the access cite was checked any day of the month. The TAR documented a blank for weights on the 9th, 12th, 14th, 19th, 21st, 23rd, 26th, and 28th. The January 2023 failed to document staff were checking/changing dialysis access cite dressing daily per plan of care. There was no documenation the access cite was checked any day of the month. The TAR documented a blank for weight on 01/02/23. There was no other documentation Resident #38 was assessed after returning from dialysis in November 2022, December 2022 and January 2023. On 01/03/23 at 10:51 a.m., Resident #38 reported they received dialysis services three times a week on MWF. They were asked if the facility sent anything with them to dialysis. They stated if the facility did, they would give it to the dialysis center to fill out. They stated it didn't happen often. They stated the dialysis center did print off their levels monthly which they brought back to the facility. They were asked if the staff assessed them when they arrived back from dialysis. They stated, No, not usually, dialysis does that. On 01/09/23 at 12:57 p.m. the DON and Administrator were asked if Resident #38 had physician orders for weights. The DON stated they did. The DON was asked how often the resident was to be weighed. She stated, Weekly weights every MWF related to ESRD. She stated weights were needed before dialysis. The DON was asked if the resident's weights for December 2023 documented blanks on the 9th, 12th, 14th, 19th, 21st, 23rd, 26th and 28th. She stated, Yes, I see that. She was asked to review the resident's weights for January 2023 and identify if 01/02/23 was blank. She stated, Do have a blank. She was asked how the facility staff communicated with dialysis. She stated communication sheets. She stated staff would also call the dialysis center and receive verbal reports on the days the resident went to dialysis. The Administrator stated staff used to use a folder, but don't anymore. They were asked where the documentation would be located. The Administrator stated another staff member would know that information. He left the room and returned with MDS Coordinator #1. On 01/09/23 at 1:20 p.m., MDS Coordinator #1 was asked where communication between the dialysis center and the facility was located. The Administrator and DON were still present in the interview. MDS Coordinator #1 stated if residents had orders that needed to be changed, the dialysis center would fax the orders to the facility. They stated the resident's record would be updated to reflect the order changes. MDS Coordinator #1 was asked if staff were assessing residents after they received dialysis and if so, where would that information be documented. MDS Coordinator #1 stated, I couldn't answer that. They were asked for any documentation Resident #38 was assessed after receiving dialysis and how the facility communicated with dialysis for the resident. There was no other documentation provided. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/23 at 6:42 a.m., Resident #38 was observed lying in bed with their television on. They were asked what type of access port they had for dialysis. They were observed moving their shirt and exposing a port located on their right upper chest. There was a gauze dressing present with no date, time or initials present. Resident #38 was asked if staff changed the dressing. They stated, No, dialysis does. They stated the facility staff only changed it if the dressing was wet. They were asked if they had any concerns with their access site. They stated they did not. They stated the last time it was changed was in the Spring at the hospital. Resident #38 was asked if the facility staff ever assessed the dialysis access site. They stated, No, dialysis does it three days a week. On 01/10/23 at 7:18 a.m., the DON was asked if they had located any documentation the resident was assess by staff when they returned from dialysis. They stated the nurse who cared for them should be assessing and documenting in a progress note. They stated, if there was an issue, then the DON would come in and assess. The DON was asked if they knew the type of access site the resident had for dialysis. They stated they believed it was a permacath, but they would find out. On 01/10/23 at 9:11 a.m., LPN #5 was asked if they were familiar with Resident #38. They stated, Yes. They were asked if the resident received dialysis services. They stated, Yes. They were asked how often. They stated, MWF. They were asked what type of site the resident had for dialysis. LPN #5 stated, Upper right chest access. LPN #5 was asked if staff assessed the site. They stated staff looked at the site every shift and especially right before the resident left for dialysis. They were asked where this was documented. They were observed reviewing the resident's record and stated it was not documented in the computer. LPN #5 was asked if staff assessed the resident when they returned from dialysis. They stated yes, the oncoming shift assessed the resident because they returned around 4:00 p.m. They were asked where the information was documented. LPN #5 was observed reviewing the resident's record and stated, I don't see anything. LPN #5 was asked how staff communicated with the dialysis center. They stated, usually residents would return with a paper that included their dry weight and last set of vital signs. They stated the form would include vitals signs before and after dialysis. They were asked where the form would be. They stated they really didn't know, because they were not at the facility when they returned. LPN #5 was given the opportunity to review Resident #38's record to locate the form mentioned. They stated, I don't know where to find that.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35389 Based on record review and interview, the facility failed to administer medications as ordered for one (#10) of five sampled residents reviewed for unnecessary medications. The Resident Census and Conditions of Residents report, dated 01/03/23, documented 71 residents resided in the facility. Findings: 35749 Resident #10 had diagnoses which included hyperlipidemia, hypothyroidism, hypertension, major depressive disorder, GERD, and insomnia. Physician's orders, dated 12/05/22, documented the following: a. atorvastatin calcium 40 mg daily, b. levothyroxine 50 mcg daily c. lisinopril 10 mg daily, d. Mirtazapine 15 mg daily, e. omeprazole 20 mg daily, and f. Trazadone 50 mg daily. MARs, dated December 2022, documented the following: a. atorvastatin was blank one out of 26 opportunities, b. levothyroxine was blank six out of 26 opportunities, c. lisinopril was blank one out of 26 opportunities, d. Mirtazapine was blank one out of 26 opportunities, e. omeprazole was blank six out of 26 opportunities, and f. Trazadone was blank one out of 26 opportunities. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/09/23 at 2:18 p.m., the Wound Care nurse was asked what the policy was for signing out medications. They stated staff would punch out the medication, initial it as given, and give it. The Wound Care nurse was asked what blanks indicated. They stated if it wasn't charted, it wasn't given. The Wound Care nurse was shown Resident #10's December 2022 MARs. They stated, That's a lot of blanks. They were asked if Resident #10's medications had been administered as ordered. The Wound Care nurse stated, No.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review, observation, and interview, the facility failed to ensure medication carts remained locked when staff were not present for two of six medication carts observed. The DON identified six carts which contained medication in the facility. Findings: A Specific Medication Administration procedures, effective 04/2018, read in part, .Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide . On 01/03/23 at 2:39 p.m., a medication cart on hall 100 was found to be unlocked and unattended. The cart was observed to contain, a bag of liquid medication, various creams, nebulizer liquids, bottles of medication, and insulin pens. On 01/03/23 at 2:41 p.m., LPN #7 stepped out of a resident room holding a specimen cup in a bag. LPN #7 states, Oh no, I'm in trouble. She stated she would be right back. LPN #7 passed the medication cart as she walked down the hall, LPN did not lock the medication cart. On 01/03/23 at 2:42 p.m., LPN #7 returned to the cart, obtained a paper from the top of the medication cart, and walked away without locking the medication cart. On 01/03/23 at 2:45 p.m., LPN #7 returned to cart, they were asked if the medication cart was locked, they stated no it is not. LPN #7 was asked what the policy was for securing medications, they stated lock the cart always. On 01/03/23 at 3:14 p.m., the medication cart for hall 100 was observed to be unlocked and unattended again. On 01/03/23 at 3:16 p.m., the medication cart located on hall 100 was observed unlocked and located outside room [ROOM NUMBER]. Various eye drops, inhalers, aspirin, allergy relief pills, and a 1000 count bottle of Tylenol 325 mg were observed to be located in the top drawer of the cart. Three additional drawers were opened by the surveyor prior to LPN #7 returning to the cart. On 01/03/23 at 3:18 p.m., LPN #7 returned to the medication cart and stated, Oh, I'm in trouble again. On 01/03/23 at 3:24 p.m., LPN #7 was asked what types of medications were in the cart. They stated this cart had a lock box which contained pain medications. They stated breathing treatments, eye drops, acetaminophen, allergy medication and insulin were also located in the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #7 was asked what the policy was for medication storage. They stated the cart should be locked. They were asked if it was ever ok for staff to walk away from a medication cart with it unlocked. They stated, No. On 01/03/23 at 3:27 p.m., the DON and ADON were asked what the policy was for medication storage on the medication carts the nurses accessed. They stated they called them treatment carts. They stated they contained prn narcotics, glucose treatment supplies, insulin, nebulizers, creams, powders, wound treatment supplies and PEG tube medications. They were asked if the cart should be locked before staff leave the cart. Both stated, Yes. The ADON stated, They should be locked anytime they walk away from the cart. The DON and the ADON were made aware of the above observations. They stated yes, they were aware. The DON stated, It is something we preach all the time. On 01/04/23 at 5:27 p.m., the treatment cart was observed unlocked at hall 200/300 nurse's station with a narcotic count book on top off the cart. Four residents were seated around the table close to the cart awaiting the evening meal. On 01/04/23 at 5:31 p.m., the DON was observed on hall 300. They walked down hall 200 asking for LPN#1. LPN#1 and DON walked from hall 200 up towards the nurse's station, the treatment cart remained unlocked. The DON was observed standing in front of the unlocked cart and then walked away. LPN #1 was observed approaching the unlocked cart donned gloves, opened the bottom drawer of the unlocked cart and retrieved a container of cleaning wipes. LPN#1 wiped the top of cart, placed container of cleaning wipes back in the bottom drawer, removed gloves, and walked away from the cart. The treatment cart remained unlocked. On 01/04/23 at 5:39 p.m., LPN#1 was observed to enter a room near the nurses' station, exited the room and walked behind nurse's station. The DON walked over to the nurses' station, near the unlocked cart, and spoke to LPN#1 and walked back over to table and assisted resident's with their meals. On 01/04/23 at 5:45 p.m., LPN#1 was observed sitting behind the nurse's station. The treatment cart remained unlocked. On 01/04/23 at 5:46 p.m., the DON was asked if there were any residents who wandered in the facility. The DON stated there were a total of three residents who wandered. On 01/04/23 at 5:50 p.m., LPN #1 was observed walking towards the treatment cart and pushed the cart down hall 200, placed the cart next to room [ROOM NUMBER], pushed in the lock securing and locking cart and walked off. The treatment cart was observed unlocked and unattended for 23 minutes. Staff were observed walking near the cart several times without noticing it was unlocked. On 01/05/23 at 4:30 p.m., the DON and the surveyor approached the medication cart which contained controlled medications located at the nurses' station where hall 200 and hall 300 meet. The DON was asked to verify the cart was observed to be unlocked. She stated, Yep. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42024 46216

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. 35389 Based on record review, and staff interview, the facility failed to obtain physician ordered labs for two (#10 and #58) of five sampled residents reviewed for laboratory services. The Resident Census and Conditions of Residents report, dated 01/03/23, documented 71 residents resided in the facility. Findings: A Lab and Diagnostic Test policy, dated September 2012, read in parts, .The physician will identify and order diagnostic and lab testing .staff will process test requisitions and arrange for tests . 1. Resident #10 had diagnoses which included hypertension, acute kidney disease, and diabetes mellitus. A Physician's Order, dated 12/06/22, documented to collect a CBC and CMP weekly for two weeks then every other week. Lab: CBC and CMP weekly x 2 then every other week. There was no documentation the labs had been collected for the week of 12/12/22. On 01/09/23 at 2:18 p.m., the Wound Care nurse was asked if Resident #10's CBC and CMP had been collected during the week of 12/12/22. The Wound Care nurse, No, ma'am. 2. Resident #58 had diagnoses which included HTN, COPD and hypothyroidism. A pharmacy Note to Attending Physician, dated 06/01/22, documented a request to obtain TSH, B12, folic acid and BMP labs. The physician response was agree to all of the above labs. No documentation the above TSH, B12 and folic acid labs were obtained was located in the resident's clinical record. On 01/10/23 at 1:37 p.m., the DON was asked what the policy was when a pharmacist made recommendations to the physician. They stated the facility received a print out to give to the physician, the physician would accept or deny the recommendation, and gave the form back to the facility. The DON was asked when the physician responded to the request, who was responsible for looking at the response. The DON stated MDS looked through them and put them into the electronic system. On 01/10/23 at 1:56 p.m., MDS Coordinator #1 was asked if Resident #58's pharmacy recommendation to the physician, dated 06/01/22, documented the physician agreed to obtain a TSH, B12, and folic acid level. They stated it did. They were asked if these labs were obtained. They reviewed the resident's record and stated, That one was not obtained. They stated another nurse who was no longer at the facility was responsible for the task. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/10/23 at 2:07 p.m., MDS Coordinator #2 stated a lot of labs had gotten missed at the time in question. They stated the BMP order was rewritten and drawn later. They were informed the labs in question were the TSH, B12, and folic acid on 06/01/22. They went back to their computer to review the records and stated, Sorry, yes that was not completed. 35749

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on observation, record review and interviews, the facility failed to have an effective administration to ensure: 1. the abuse policy was followed regarding allegations of misappropriation of pain medication signed out and not documented as administered for three (#36, 38 and #54) of five sampled residents reviewed for pain and controlled medication count records were verified by two licensed nurses when removed from circulation and placed into the drawer for controlled medications awaiting destruction for 10 (#11, 36, 43, 48, 66, 70, 127, 128,129, and #130) of 11 sampled residents reviewed for controlled medications awaiting destruction. 2. a resident had necessary intervention, monitoring, and care to prevent the development and worsening of an avoidable pressure injury/pressure ulcer for one (#11) of three sampled residents reviewed for pressure ulcers. 3. coordination of care with a third party dialysis center, failed to obtain weights as ordered, and failed to assess a resident after returning from dialysis for one (#38) of one sampled resident reviewed for dialysis services. 4. ensure neuro checks and post fall assessments were completed for one (#41) of one sampled residents reviewed for falls. 5. provide baths/showers to dependent residents for four (#10, 31, 38, and #54) of nine sampled resident's reviewed for ADLs. 6. and failed to provide personal care to residents in a manner which prevented cross contamination for four (#2, 11, 57 and #58) of four sampled residents observed during incontinent care and staff wore mask during a COVID-19 outbreak and the facilities community transmission rate was high. The Resident Census and Conditions of Residents report, dated 01/03/23, documented 71 residents resided in the facility. Findings: 1. a. Resident #36 had diagnoses which included End-Stage Renal Disease and depression. Resident #36's Controlled Drug Receipt/Record/Disposition form, date received 12/23/22, documented oxycodone/acetaminophen tab 10/325mg take one tablet by mouth every four hours as needed. It documented one pill was signed out on the following dates/times: 12/29 at 11:30 a.m., 12/30 at midnight, 12/30 at 4:00 a.m., 01/03 at 6:30 a.m., 01/03 at 6:06 p.m. and one on 01/04 at 6:30 a.m. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36's Controlled Drug Receipt/Record/Disposition form, date received 12/27/22, documented oxycodone/acetaminphen 5/325mg take one tablet by mouth (take with 10mg to equal 15mg) every four hours as needed. It documented one pill was signed out on the following dates/times: 12/29 at 11:30 a.m., 12/30 at midnight, 12/30 at 4:00 a.m., 01/03 at 6:30 a.m., 01/03 at 6:06 p.m. and one on 01/04 at 6:30 a.m. Resident #36's December 2022 MAR/TAR did not document the above medications were administered to the resident. Resident #36's January 2023 MAR/TAR did not document the above medications were administered to the resident. On 01/04/23 at 6:28 a.m., LPN #1 was observed responding to a call light in room [ROOM NUMBER]. LPN #1 remained in the surveyor's line of sight from 6:28 a.m. through 7:20 a.m. On 01/04/23 at 7:20 a.m., LPN #1 was observed conducting a count of the controlled medications located on their medication cart with LPN #3. When they came to Resident #36's oxycodone/acetaminophen 10/325mg, LPN#1, who was reviewing the count book called out, 19, LPN #3 who was looking at the carded controlled medications on the cart, called out, 18. LPN #1 was observed signing out one pill on the count sheet and documented the time as 6:30 a.m. Both nurses continued on with the count. The next card for Resident #36 oxycodone/acetaminophen 5/325mg, LPN #1, who was reviewing the count book called out, 50. LPN #3 who was looking at the carded controlled medication called out, 49. Again, LPN #1 was observed signing out one pill and documented the time at 6:30 a.m. LPN #1 was asked to explain signing out these medications for the time of 6:30 a.m. They stated, That's when I gave it. LPN #1 was asked to explain the reason they signed out both medications when the count was noted to be wrong. They stated, I forgot to sign it out. They stated, That's all I can tell you. LPN #1 was asked the policy for administering controlled medications. They stated, Punch, sign, give. They stated, That's how we're supposed to do it. Both LPN #1 and LPN#3 failed to follow the Medication Storage in the Facility policy because they failed to immediately report any discrepancy in controlled substance counts to the DON. b. On 01/05/23 at 3:10 p.m., The DON was observed removing controlled medications awaiting destruction from the top drawer of a file cabinet located in the closet in the DON's office. She was asked to explain the process for when a controlled medication was discontinued or the resident discharged . She stated there would be a discontinue order. She stated staff would remove the medication and the log sheet from the cart. She stated staff would bring both to her, verify the count, the DON and the staff who brought it to her would initial the count. Controlled medication count records were observed to be missing double signatures verifying the count prior to the medications being placed in the drawer for destruction for residents #11, 36, 43, 48, 66, 70, 127, 128, 129, and #130. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/06/23 at 12:16 p.m., the Pharmacist was if they knew the process of when a controlled medication was brought to the DON for destruction. They stated staff would take the medication to the DON or the DON would go and get the medication. They stated the DON and the staff who brought the medication would verify the count and sign off on the count sheet. They stated it was best practice, anytime a controlled medication changed hands for both staff to sign/verify the count. On 01/10/23 at 3:16 p.m., the Administrator was asked what the administrative process was for tracking controlled medications to prevent misappropriation. He stated the pharmacy checked the carts, the DON checked the carts, Nursing checked the carts. He stated they would report anything seen missing, whoever is held accountable, and that the medication was found and accounted for. 2. This resulted in actual harm by Resident #11 developing a pressure injury which worsened to an avoidable pressure injury with slough visible. The facility failed to ensure: a. Thorough skin assessment was conducted on readmission, b. Weekly skin monitoring and/or weekly wound assessments were conducted, c. The physician was notified timely of the new or worsening wound; and d. Adequate wound care/treatment was initiated timely. On 01/10/23 at 3:25 p.m, the Administrator and MDS Coordinator #1 and MD Coordinator #2 were asked what the administration involvement was related to prevention/worsening of skin breakdown. MDS Coordinator #1 stated the facility had a wound nurse in house who conducted skin assessments. They were asked how often. They stated weekly and audits of skin assessments were completed. They stated there was a wound care team that came in twice weekly and a dietician who consulted as needed. They were asked if administration had any involvement on assessments when a resident left for the hospital and returned to the facility. MDS Coordinator #1 was observed shaking their head no. 3. Resident #38 had diagnoses which included ESRD. Resident #38's Physician Order, dated 12/14/20, documented the resident was to receive dialysis three times weekly on an out patient basis MWF at 10:00 a.m. Resident #38's most recent Hemodialysis Communication Form was dated 11/20/21. There was no other documentation Resident#38 was assessed after returning from dialysis in November 2022, December 2022 and January 2023. On 01/03/23 at 10:51 a.m., Resident #38 reported they received dialysis services three times a week on MWF. They were asked if the facility sent anything with them to dialysis. They stated if the facility did, they would give to the dialysis center to fill out. They stated it didn't happen often. They stated the dialysis center did print off their levels monthly which they brought back to the facility. They were asked if the staff assessed them when they arrived back from dialysis. They stated, No, not usually, dialysis does that. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/09/23 at 12:57 p.m. the DON was asked how the facility staff communicated with dialysis. She stated communication sheets. She stated staff would also call the dialysis center and receive verbal reports on the days the resident went to dialysis. The Administrator stated staff used to use a folder, but don't anymore. They were asked where the documentation would be located. The Administrator stated another staff member would know that information. He left the room and returned with MDS Coordinator #1. On 01/09/23 at 1:20 p.m., MDS Coordinator #1 was asked where communication between the dialysis center and the facility was located. The Administrator and DON were still present in the interview. MDS Coordinator #1 stated if residents had orders that needed to be changed, the dialysis center would fax the orders to the facility. They stated the resident's record would be updated to reflect the order changes. MDS Coordinator #1 was asked if staff were assessing residents after they received dialysis and if so, where would that information be documented. MDS Coordinator #1 stated, I couldn't answer that. They were asked for any documentation Resident #38 was assessed after receiving dialysis and how the facility communicated with dialysis for the resident. On 01/10/23 at 6:42 a.m., Resident #38 was observed lying in bed with their television on. They were asked what type of access port they had for dialysis. They were observed moving their shirt and exposing a port located on their right upper chest. There was a gauze dressing present with no date, time or initials present. Resident #38 was asked if staff changed the dressing. They stated, No, dialysis does. They stated the facility staff only changed it if the dressing was wet. On 01/10/23 at 3:16 p.m. the Administrator was asked several questions regarding the administrative process, he stated several were nursing related areas and he was unable to answer. The Administrator was given the opportunity to bring any administrative personnel into the interview who could answer the questions. On 01/10/23 at 3:25 p.m., MDS Coordinator #1 joined the interview. They were asked what the administrations involvement was with the coordination of care with a third party. MDS Coordinator #1 stated if the resident came back with dialysis orders, staff would put the orders in the electronic record. They stated MDS was a back up. They were asked if the administration had any involvement with the assessments of these resident when they came back. MDS Coordinator #1 shook their head no. The Administrator did not respond. 4. Resident #41 has two incidents involving unwitnessed falls. The staff failed to assess the resident post fall and failed to complete neuro checks. On 01/10/23 at 3:16 p.m., the Administrator was asked what the administrations involvement related to resident assessments after falls was. He stated he had nothing to do with that. He stated he did not assess residents. The Administrator was asked what administrative staff would give facility staff information related to assessing residents after falls. He stated nursing administration. He stated the DON and the ADON would complete inservices. The Administrator was given the opportunity to bring any administrative personnel into the interview who could answer the questions. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/10/23 at 3:23 p.m., he returned with MDS Coordinator #2. The Administrator was asked if the staff member was part of Administration. He stated, Yeah. MDS Coordinator #2 was informed the survey team had questions related to the administration's involvement related to falls. MDS Coordinator #2 stated they were not the person who would know this. On 01/10/23 at 3:25 p.m., MDS Coordinator #1 joined the interview. MDS Coordinator #1 was asked the administration's involvement related to falls. They stated they went through risk management to find out what happened with the fall and what interventions were in place. They stated IDT went over the information and updated care plans. They stated all nurses had access to the care plan. 5. The facility failed to provide bath/showers for residents #10, 31, 38, and #54. The clinical records documented the residents were not receiving their baths/showers per schedule. On 01/10/23 at 3:16 p.m., the Administrator was asked what the administrative process was for ensuring residents received their baths/showers as scheduled. He stated, checking shower sheets and going over staff responsible to make sure they were done on a consistent basis. 6. Residents #2, 11, 57 and #58 were observed during incontinent care. Staff were observed failing to change gloves when going from dirty to clean, throwing soiled linens on the floor, transporting soiled linens through the hall without placing them in a bag, putting a trash can on a resident's bed during care and touching clean items with contaminated gloves. Staff were observed not wearing masks when the facility was in a Covid 19 High County. On 01/10/23 at 3:16 p.m. the Administrator was asked what the administration's role was regarding infection control. He stated by ensuring the medical director and the QA committee was tracking and trending related to infection control. The Administrator was asked who was responsible for overseeing overall inservices. He stated if it was nursing related, the DON. He stated the State Department of Health sets forth what topics the facility was required to inservice on. The Administrator was asked with these areas of deficient practice, were administrative processes effective. He stated, Yes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review, observation, and interview, the facility failed to: a. provide personal care to residents in a manner which prevented cross contamination for four (#2, 11, 57 and #58) of four sampled residents observed during incontinent care, and b. ensure staff wore masks during a COVID-19 outbreak and the facilities community transmission rate was high. The Resident Census and Conditions of Residents report, dated 01/03/23, documented 71 residents resided in the facility. Findings: A COVID-19 Resident and Staff Guidance/Outbreak Protocol policy, revised 10/25/22, read in part, . Guidance for Staff .When community transmission levels are high (surgical mask or N-95) . A Laundry and Bedding, Soiled policy, revised July 2009, read in part, .Place contaminated laundry in a bag or container at the location where it is used .Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items A Diarrhea and Fecal Incontinence policy, revised September 2010, read in part, .Disposable items soiled with feces .must be handled so as to prevent contamination of the environment with feces. Such items must be placed in closed containers in the soiled utility room and discarded in accordance with established procedures . 1. Resident #2 had diagnoses which included obesity and unspecified dementia. On 01/04/23 at 6:03 a.m., CNA #2 and CNA #5 were observed providing incontinent care to Resident #2. During care, after cleaning urine from the resident's left buttock, CNA # 5 was observed picking up a container of calmazine with the same gloves used during incontinent care. They squeezed some cream onto their glove, and placed the container back on the shelf in the resident's room. CNA #5 put the calmazine on the resident's buttock, removed and replaced gloves and rolled the resident to the left side. CNA #2 removed the soiled underpad from under the resident and placed it on the floor next to the resident's bed. They both attached the new brief and adjusted the resident's blankets. CNA #2 then picked up the soiled pad off of the floor and transported it to the soiled utility room. The CNA failed to place the soiled item in a bag prior to transporting it down the hall. On 01/04/23 at 6:10 a.m., CNA #2 was asked if they placed soiled linens on the floor. They stated, Yeah. They were asked if they placed soiled linens in a bag prior to taking them to the soiled linen room. They stated, No, I did not. They were asked if they were aware of the policy for transporting soiled linens. They stated they were not. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #57 had diagnoses which included cognitive communication deficit and lack of coordination. Resident #57's Five Day Resident Assessment, dated 11/13/22, documented moderate cognitive impairment and the resident required limited one person physical assistance for toilet use and personal hygiene. It documented the resident was occasionally incontinent of bowel and bladder. Resident #57's Care Plan, revised 11/22, documented the resident was at risk for urinary incontinence. It documented interventions which included assist with toileting as needed and provide incontinent care. On 01/04/23 at 5:41 a.m., CNA #2 and CNA #5 entered Resident #57's room to provide personal care. Both CNAs donned gloves. Resident #57 requested a blanket. CNA #2 left the room. On 01/04/23 at 5:47 a.m., CNA #2 returned to the room with a blue disposable, yellow brief, two blankets and a white non disposable pad. They donned gloves. CNA #2 opened up the yellow disposable brief. CNA #5 was observed exposing the resident's brief which was wet. There was a yellow stain noted on the non disposable pad under the resident. CNA #2 opened the brief rolled it under the resident from the front and grabbed several wipes in their hand. They used this handful of wipes and wiped the resident's peri area down the center, then the right side then the left side then down the middle again with the same handful of wipes. CNA #2 then threw these away. Resident #57 was turned to their right side, CNA #2 rolled the soiled brief under the resident and took out a handful of wipes. They used the same handful of wipes and wiped the resident up then down then up again then up again removing urine from the resident with the same handful of wipes. CNA #2 placed the wipes in the trash. CNA #2 rolled up the old pad under the resident, placed the new disposable, pad and white blanket with blue lines on it under the resident. The resident was rolled to the left side, CNA #5 removed the soiled items, and pulled the new items through. CNA #2 placed the soiled pad on the resident's floor by the trash can. CNA #5 used one wipe to wipe the resident several times, threw it away, and adjusted the new disposable brief and white blanket used as a draw sheet. Resident #57 began urinating prior to the end of care. CNA #2 stated the resident had urinated on the new pad. CNA #2 removed the old pad from the floor, transported it through the hall, and placed it into the soiled utility room with one gloved hand. The soiled pad was not placed in a trash bag prior to transporting it through the hall. CNA #2 removed their other glove and threw it away in the soiled utility room. They went to the clean linen shelf and obtained a new gown and returned to the room. CNA #2 stated, We don't have a new pad. They stated, We will do the best with what we have. CNA #5 removed the old gown. CNA #2 donned gloves and placed the new gown on the resident. CNA #2 stated they were going to wait and come back to change Resident #57 later. They removed the top two blankets from the resident, threw them on the floor and placed two new blankets on the resident. CNA #2 removed the trash bag and picked up the soiled items off of the floor and took the soiled gown from CNA #5. CNA #2 transported these items through the hall, opened the soiled utility door with a gloved hand, and placed them in the soiled linen barrel. CNA #2 did not place the items into a trash bag prior to transporting them down the hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #2 was asked if they took a handful of wipes and wiped the resident on the right, left, and center of their peri area with the same handful of wipes. They stated, I believe so. They were asked if they typically used the same wipes several times. They stated, Not typically. CNA #2 left the interview and entered another resident's room. On 01/04/23 at 6:10 a.m., CNA #2 was asked if they had changed gloves after providing incontinent care and removing soiled brief, prior to touching the new clean items used. They stated, No, I did not. They were asked what the yellow stain was on the nondisposable pad. They stated it was pretty obviously urine. CNA #2 was asked the reason they left the pad the resident urinated on during care under the resident. They stated they planned on checking back on the resident after making rounds. They were asked if they had placed soiled linens on the floor. They stated, Yeah. They were asked if they placed soiled linens in a bag prior to taking them to the soiled linen room. They stated, No, I did not. They were asked if they were aware of the policy for transporting soiled linens. They stated they were not. On 01/04/23 at 1:00 p.m. the DON was asked what direction staff were instructed to go when providing incontinent care. They stated, Front to back. The DON was asked what staff were instructed to do with soiled linens. They stated staff should place them in a plastic bag and transport them to the yellow soiled linen barrel. The DON was asked the policy for when a staff member observed a soiled item under a resident. They stated if an item was visibly soiled, it needed to be removed and replaced. 3. Resident #58 had diagnoses which included diabetes mellitus, lack of coordination and morbid obesity. Resident #58's Care Plan, revised 08/26/22, documented the resident had an ADL self-deficit related to impaired balance and limited mobility. It documented the resident was at risk for urinary incontinence. It documented interventions which included assist with toileting as needed and provide incontinent care. Resident #58's Quarterly Resident Assessment, dated 11/15/22, documented the resident's cognition was intact and required extensive two person physical assistance for the task of personal hygiene and toilet use. It documented the resident was occasionally incontinent of urine and always incontinent of bowel. On 01/03/23 at 2:48 p.m. CNA #1 and CNA #4 entered resident #58's room without masks on, sanitized their hands, donned gloves, closed the window shade and pulled the privacy curtain. CNA #1 obtained a new folded sheet (used as a draw sheet), non disposable pad and a disposable brief and laid them out beside the resident. There were no wipes available. CNA #4 removed their gloves, obtained disposable wipes from outside the room, returned, sanitized hands and donned gloves. CNA #1 rolled up the clean items next to the resident. Both CNA's unfastened the resident's disposable brief and CNA #4 rolled the brief under the resident from the front. CNA #4 took a wipe and wiped the right side of the resident's scrotal area, then the left side, then down the center with the same wipe and threw it in the trash. The resident was turned to the right side facing CNA #4. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #1 provided peri care to the resident, removed the soiled disposable brief, threw it away, and removed their soiled gloves. CNA #1 placed the new rolled items under the resident's old items. Resident #58 was then rolled to their left side, CNA #4 removed the old sheet and blanket from under the resident and threw it on the floor. CNA #1 placed the trash can on the resident's bed. CNA #4 used three disposable wipes one wipe per swipe to remove stool from the resident. Then without removing their gloves, CNA #4 pulled the new items under the resident, adjusted the new disposable brief and pulled the resident's gown down. CNA #4 removed the trash and their gloves and transported the trash to the soiled utility room. CNA #4 returned to the resident's room and washed their hands with soap and water. The soiled linens remained on the resident's floor. CNA #4 was asked if they were finished. They stated, Yes. CNA #4 was asked if they removed their gloves after providing incontinent care which involved stool, prior to pulling the new items under the resident, fastening the new disposable shut, and adjusting clean items. They stated, Not this time. They stated they should have put on new gloves after removing stool from the resident. CNA #4 was asked if they placed the old sheet and blanket, which they removed from under the resident, on the floor. They stated, Yes. CNA #4 was asked if CNA #1 placed the trash can on the resident's bed during care for them to throw wipes away in. No response given. They were asked if they typically placed a trash can on the resident's bed. They stated, I don't. CNA #4 was asked the policy for handling soiled linens. They stated when staff removed the linens, they would put the items on the floor. They stated when care was complete, they were supposed to remove the linen from the floor and place it in the linen barrel before washing their hands. On 01/03/23 at 3:45 p.m., the DON and ADON were asked the policy for changing gloves when providing incontinent care. The DON stated staff were to change gloves as often as they needed to. They stated the policy was to change gloves when going from dirty to clean. They stated staff should sanitize then re-glove. They were asked what staff were instructed to do with the linens they removed from under a resident during incontinent care. The ADON stated staff should be placing the items in a bag to be transported in the hall to prevent cross contamination. They stated the items should never be placed on the floor. They were asked if it was ever ok for staff to place the trash can on the resident's bed during care. Both stated, No. 42024 4. Resident #11 had diagnoses which included chronic pain, obstructive sleep apnea, osteoporosis, hypertension, prostatic hyperplasia, muscle spasms, and physical debility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375534	A. Building B. Wing	01/10/2023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11's discharge return anticipated assessment, dated 12/23/22, documented the resident's cognition was severely impaired, and they required extensive to total assistance of one to two staff members for all ADL care. The assessment documented resident was incontinent of bowel and bladder. On 01/03/23 at 12:03 p.m., incontinent care was observed being performed on Resident #11 by CNA #6 and CNA #7. CNA #7 entered the room, donned gloves, no hand hygiene performed. CNA #7 walked over to resident's right side, picked up bed remote from floor and proceeded to place head of bed down. CNA #6 entered room with linen and placed the linen at the foot of the bed and observed donning gloves no hand hygiene performed. CNA #7 turned resident on left side towards CNA #6. CNA #6 held onto resident's upper back and hip, a brown ring was observed up to mid back and down to mid-calf. An unfasten adult incontinent brief was observed saturated with urine. CNA #7 was observed to pull wipes out of the package and wiped the resident buttocks. CNA #7 then removed the soiled fitted sheet from mattress and tucked it under resident, the resident was then rolled to left side and CNA #6 wiped resident's back and buttocks and pulled the soiled linen from under the resident. CNA #7 picked up the soiled linen and threw the soiled linen on floor. CNA #7 placed clean linens and an open unfasten adult incontinent brief under the resident. There was no glove change and no hand hygiene performed prior to touching clean items. The resident was turned left and right until the clean linen was placed securely on the mattress. On 01/03/23 at 12:10 p.m., CNA #6 walked over to the right side of the resident, picked up oxygen nasal cannula tubing from the floor and placed it in the resident's nostrils with unchanged gloves. CNA #7 and CNA #6 both placed a clean gown on the resident without changing their gloves. A top sheet and a blanket were placed on the resident and pillows were placed under their feet. No hand hygiene nor glove change were performed. CNA #6 picked up dirty linen off the floor and exited the room. On 01/03/23 at 12:14 p.m., CNA #7 and CNA #6 were asked if there was anything they would have done differently during incontinent care. Both stated, No, I don't know. They were asked if they performed hand hygiene. CNA #7 stated, No and I did not change gloves. CNA #6 stated, I washed my hands before I got linen. CNA #6 was asked if they performed hand hygiene or glove change when going from dirty to clean. CNA #6 stated, I did not. 46216 5. When the survey team entered the facility on 01/03/23 at 7:37 a.m., the facility was noted to be in a high community transmission rate for COVID-19. On 01/03/23 at 5:48 a.m., six clean briefs were observed sitting on top of a yellow barrel labeled soiled linens. On 01/03/23 at 5:50 a.m., CNA #2 was asked what the items were on top of the yellow barrel, they stated clean briefs. CNA #2 stated the barrels were for soiled laundry and trash. CNA #2 was not wearing a mask. On 01/03/23 at 5:52 a.m., CNA #3 was asked what the facility policy was regarding placing clean items on top of contaminated surfaces. They stated the barrels should be in the soiled closet and the briefs should have remained in the clean linen closet until needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/03/23 at 5:53 a.m., CNA #3 removed briefs from the top of the barrel and took them to the clean linen closet. They placed the briefs on a metal rack observed in the clean linen closet. On 01/03/23 at 6:01 a.m., CNA #3 entered the clean linen closet and obtained a brief from the shelf that she had placed on the metal rack just before. On 01/03/23 at 6:02 a.m., CNA #3 entered room [ROOM NUMBER] room with a contaminated brief. 6. On 01/03/23 at 11:15 a.m., CMA #3 passing medications to residents, was observed not wearing a mask. On 01/03/23 at 1:44 p.m., CNA #1 was observed outside room [ROOM NUMBER] without a mask in place. On 01/03/23 at 2:48 p.m. CNA #1 and CNA #4 were observed entering resident #58's room to provide care. No masks were observed on either staff member. On 01/04/23 at 1:00 p.m., the DON was asked if it was acceptable for staff to place clean briefs on top of the soiled linen barrel, remove the briefs, place back on the clean rack, then use the briefs during resident care. They stated, No, should have been thrown away. On 01/04/23 at 10:52 a.m., the DON reported the facility had three residents test positive for COVID-19 on 01/03/23 at 5:30 p.m. Resident in rooms 400 A and B and the resident in room [ROOM NUMBER] P were identified as being positive for COVID-19. All days of survey from 01/03/23 until exit of 01/10/23, the DON was observed throughout the facility without a mask. On 01/11/23 at 1:54 p.m., the Administrator was asked who their IP person was. He stated he was. He was asked what staff were instructed to do regarding mask. He stated that the facility followed guidelines of OSDH in regards to wearing mask. He stated that staff were to wear mask when the facilities community COVID-19 transmission rate was high and when in a COVID-19 outbreak.