STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. Building B. Wing	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Horn Rehabilitation and Care Center	1851 Big Horn Ave Sheridan, WY 82801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on observation, medical record and policy and procedure review, and resident and staff interview, the facility failed to ensure residents were treated with dignity during 3 random observations which affected residents #13, #43, and #70. The findings were: 1. Review of the 12/28/22 quarterly MDS assessment showed resident #13 was admitted to the facility on [DATE] with a BIMS score of 11/15 (moderate cognitive impairment), a diagnosis of diabetes mellitus, and received insulin injections 7 days of the 7-day look-back period. The following concerns were identified: a. Observation on 2/5/23 at 5:25 PM showed the resident was seated in the Rock Creek dining room awaiting the evening meal. LPN #1 approached the resident at the table to perform a fingerstick to check his/her blood sugar level using a glucometer. After obtaining the blood sugar level, LPN #1 prepared an insulin pen and proceeded to inject the insulin into the resident's bare abdomen. The resident's abdomen was visible to the surveyor standing across the dining room. There were approximately 20 residents and staff in the dining room at that time. b. Interview with the resident on 2/6/23 at 10:16 AM revealed his/her blood sugar was always tested and insulin injected at the dining room table. c. Interview with LPN #1 on 2/5/23 at 5:28 PM revealed she routinely checked blood sugars and injected insulin in the dining room during the evening meal because, It is nearly impossible to do it in their rooms because they are on the move so much. 2. Review of the 12/11/22 quarterly MDS assessment showed resident #43 was admitted to the facility on [DATE] with a BIMS score of 15/15 (cognitively intact), had a diagnosis of diabetes mellitus, and received insulin injections 7 days of the 7-day look-back period. The following concerns were identified: a. Observation on 2/5/23 at 5:33 PM showed the resident was seated in the Rock Creek dining room awaiting the evening meal. LPN #1 approached the resident at the table to perform a fingerstick to check his/her blood sugar level using a glucometer. After obtaining the blood sugar level, LPN #1 prepared an insulin pen and proceeded to inject the insulin into the resident's bare abdomen. The resident's abdomen was visible to the surveyor standing across the dining room. There were approximately 20 residents and staff in the dining room at that time. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the 12/18/22 admission MDS assessment showed resident #70 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury and morbid obesity. The resident required extensive assistance of two or more staff members for transfers and personal hygiene. The following concerns were identified: a. Observation on 2/6/23 at 10:51 AM showed the resident was in a shower chair in the hallway. The resident had on a green gown and a bath blanket was draped over the back side of the shower chair. The resident's ribs to buttocks were exposed on each side of his/her body as well as his/her buttocks on the bottom of the chair. b. Interview with occupational therapist #1 revealed she normally did not give showers and used the shower chair due to the resident's size. She further stated that she was unaware the resident had exposed skin. 4. Interview with the DON on 2/7/23 at 2:49 PM revealed the residents had requested blood sugar checks and insulin injections be given in the dining room. In addition, the DON stated it was the facility's expectation residents' skin not be exposed in common areas. Further interview with the DON on 2/8/23 at 10:02 AM confirmed there was no documentation which showed it was the residents' preference to have medications administered and blood sugar levels checked in the dining room. 5. Review of the 2001 MED-PASS, Inc. (revised February 2021) Dignity policy showed .5. e. provided with a dignified dining experience .11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 F554 Based on observation, resident and staff interview, medical record review and policy review, the facility failed to ensure residents who self-administered medications were assessed and determined safe to do so by the interdisciplinary team for 3 random observations which affected residents #5, #56 and #278. The findings were: 1. Review of the 11/7/22 quarterly MDS assessment showed resident #5 was admitted to the facility on [DATE] with a diagnosis of cerebral palsy. Further review of the MDS assessment showed a cognitive assessment had not been completed. The following concerns were identified: a. Observation on 2/6/23 at 10:11 AM showed 9 medications were located on a blue-topped tray table located in the resident's room. There was no nursing staff in the vicinity of the resident's room. b. Review of the medical record showed no evidence a medication self-administration assessment had been completed. 2. Review of the 2/6/23 resident admission record showed resident #278 was admitted to the facility on [DATE] with diagnoses which included unspecified severe protein-calorie malnutrition, essential hypertension, encounter for surgical after care following surgery on the digestive system and chronic obstructive pulmonary disease. Further review of the 2/6/23 Brief Interview for Mental Status tool showed a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The following concerns were identified: a. Review of the Nursing Admission Data Collection tool dated 2/5/23 at 4:34 AM showed resident #278 resident did not wish to self-administer medications. b. Observation on 2/7/23 at 8:55 AM showed resident #278 sitting in the Rock Creek dining room with 2 other residents. The resident was observed with 2 small cups of medications in pill and capsule form, and a small cup of liquid in front of him/her, and no nurse or medication aide was in the vicinity of the dining room. Interview with the resident at that time revealed s/he did not know what medications in front of him/her were or what they were for. The resident also stated s/he had not been evaluated for or requested to self-administer medications. The nurse was not present to observe administration of the medications. c. Further review of the medical records failed to show any assessment for the ability to safely self-administer medications had been performed. 3. Review of the 11/22/22 admission MDS assessment showed resident #56 was admitted to facility on 11/16/22 with diagnoses which included chronic respiratory failure with hypercapnia, muscle weakness, idiopathic epileptic syndromes with seizures and a history of falls, and a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The following concerns were identified: (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Observation on 2/7/23 at 8:10 AM showed CNA #3 approached RN #3 and asked what the medications were in the medication cups left for resident #56 because the resident did not remember. The RN responded to the CNA Folic acid and normal stuff. Further observation at the time showed there were medications left unattended on the resident's bedside table in 2 small cups, one small cup with red liquid and another with 5 medications in pill form. Interview with the resident at that time revealed the nurse was in a hurry so s/he left the medications. The resident also stated s/he had not been evaluated for or requested to self-administer medications. The nurse was not present to observe administration of the medications. b. Further review of the medical record failed to show any assessment for the ability to safely self-administer medications had been performed. 4. Interview with the CNA #3 on 2/7/23 at 8:50 AM confirmed the nurses usually left the medications for resident #56 at bedside and unattended. 5. Interview with RN #3 on 2/8/23 at 12:51 PM confirmed the medications were left at the dining room table for resident #278 and at the resident bedside table for resident #56 stating both residents were alert. Furthermore, the RN stated they were just normal medications and no narcotics were left unattended. 6. Interview with the DON on 2/8/23 at 12:50 PM confirmed the residents' medication self-administration assessments had not been completed. 7. Review of the facility policy Self-Administration of Medications, last revised February 2021, showed Residents may have the right to self-administer medications if the medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 47344

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37220 Based on medical record and Resident Assessment Instrument (RAI) user's manual review, and staff interview, the facility failed to ensure the MDS assessment information was an accurate reflection of resident status for 3 of 21 sample residents (#1, #5, #15). The findings were: 1. Review of the 12/23/22 quarterly MDS assessment showed the cognitive and mood assessments had not been completed for resident #1. 2. Review of the 11/7/22 quarterly MDS assessment showed the cognitive and mood assessments had not been completed for resident #5. 3. Review of the 1/23/22 quarterly MDS assessment showed the cognitive and mood assessments had not been completed for resident #15. 4. Interview with the MDS coordinator on 2/6/23 at 2:54 PM confirmed the cognitive and mood assessments had not been completed within the required 7-day look-back period. 5. Review of the RAI 3.0 user's manual, version 1.17.1 Section C (cognitive patterns) and Section D (mood) showed .Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47344 Based on medical record review, and resident and staff interview, the facility failed to develop and implement baseline care plans for 5 out of 5 (#64, #72, #74, #277 and #278) residents resulting in failure to provide a continuity of care, effective and person centered care. 1. Review of the 12/22/22, admission MDS assessment showed resident #64 was admitted on [DATE] with a BIMS score of 15/15 which indicated the resident was cognitively intact, and had diagnoses which included non-traumatic chronic subdural hemorrhage, need for assistance with personal care, repeated falls, diabetes mellitus, moderate protein-calorie malnutrition, and stroke. The following concerns were identified: a. Review of baseline care plan (effective 12/18/22) interventions failed to identify person-centered care for fall management, diabetic management, ADL function, and food and nutrition management. Interview with the resident on 2/5/23 at 4:30 PM at that time revealed he was diabetic, had recent falls and poor appetite. 2. Review of the 12/9/22 admission MDS assessment for resident #72 showed the resident was admitted on [DATE], had a BIMS score of 7/15 which indicated the resident had severely impaired cognition, and diagnosis which included fractures and other multiple trauma, vision loss, fracture related to a fall, history of falling, and mixed incontinence. Further review showed a pain intensity of 10/10 indicating the worst pain possible and malnutrition. The following concerns were identified: a. Review of the medical record failed to show evidence a baseline care plan was initiated within 48 hours of the resident's admission. 3. Review of medical record Review of medical record effective 1/10/23 admission MDS assessment showed the resident #74 was admitted on [DATE] with a BIMS score of 9/15 which indicated the resident had moderate cognitive impairment with diagnoses which included diabetes mellitus, dementia, other fracture, abnormal weight loss, and need for personal assistance. The following concerns were identified: a. Review of baseline care plan effective 1/5/23 failed to identify person-centered care interventions for fall management, pain management, ADL function, and food and nutrition management. 4. Review of the medical record dated 1/31/23 admission MDS assessment for resident #277 showed the resident was admitted on [DATE] with a BIMS score of 12/15 which indicated the resident had moderately impaired cognition and diagnoses which included urinary tract infection, sepsis due to pseudomonas, bipolar disorder, dependence on supplemental oxygen, unsteadiness on feet, need for assistance with personal cares. The following concerns were identified: a. Review of the medical record failed to show evidence a baseline care plan was initiated within 48 hours of admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record dated 2/9/23 for the admission MDS assessment for resident #278 showed the resident was admitted to the facility on [DATE], had a BIMS score of 15/15 which indicated the resident was cognitively intact, a pain evaluation completed on 2/5/23 indicating the resident had a score of 8 of very severe pain and diagnoses which included diabetes mellitus, hypertension, anemia, arthritis, gastrostomy status and malnutrition. The following concerns were identified: a. Review of the resident's baseline care plan printed on 2/6/23 failed to show person-centered care interventions for fall management, pain management, ADL function, bowel function and food and nutrition needs. Interview with the resident on 2/6/23 at 1:00 PM revealed the resident had arthritic pain, recent surgeries and his/her blood sugar was too high on 2/5/23. 6. Interview with ADON on 2/7/23 at 4:29 PM confirmed the facility failed to develop baseline care plans that included instructions needed to provide effective and person-centered care to newly admitted residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25745 Based on medical record review and staff interview, the facility failed to ensure 2 of 21 sample residents (#34, #47) had resident-specific care plans that reflected individual needs in all required areas. The findings were: 1. Review of the 12/31/22 quarterly MDS assessment showed resident #34 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, schizophrenia, chronic obstructive pulmonary disease, and chronic atrial fibrillation. The review showed the resident required extensive assistance of 1 staff for personal hygiene and toileting. Review of the 1/16/23 Braden Scale assessment showed the resident scored a 15, which showed the resident was at risk for developing a pressure ulcer. Review of the 1/1/23 weekly skin assessment showed the resident had no pressure ulcers or skin issues at that time. Review of the 1/5/23 weekly skin assessment showed the resident had a right heel pressure ulcer. Interview with the DON on 2/7/23 at 3:44 PM confirmed the facility identified a pressure ulcer on the resident's right heel on 1/2/23. Review of the care plan showed the resident had a plan to address pressure ulcers on 12/8/18. The following concerns were identified: a. Review of the entire medical record showed the facility failed to perform a Braden Scale assessment for pressure ulcer risk on the resident prior to 1/16/23 (14 days after identification of a right heel pressure ulcer). b. Review of the care plan showed a 12/8/18 focus for actual impairments to skin integrity, which was revised 1/2/23 to include pressure injury to the resident's right heel. Further review showed the plan was revised on 1/29/23 (27 days after identification of the right heel pressure ulcer) to include an off-loading boot to the right foot to prevent further pressure injury, and continued review showed no plan related to repositioning or off loading until that time. Review of the progress notes showed the resident's right foot was being utilized on 1/6/23. c. Interview with the DON on 2/7/23 at 3:44 PM confirmed the facility failed to perform a Braden Scale assessment for pressure ulcer risk prior to the resident developing a pressure ulcer. She further confirmed the facility failed to initiate timely care plan interventions to address floating or off-loading the resident's heels until 1/29/23 (27 days after the identification of the pressure ulcer), and then the plan only addressed the right heel. 2. Review of the 12/13/22 quarterly MDS assessment showed resident #47 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus II, anxiety disorder, and chronic obstructive pulmonary disease. The review showed the resident required the extensive assistance of 1 person with personal hygiene. Review of physician orders showed an 8/25/22 order for Seroquel (anti-psychotic) 100 mg by mouth daily. Review of the January and February 2023 MARs showed the resident continued to receive Seroquel as ordered. Review of the care plan showed the resident had a 12/24/22 plan for anti-psychotic use regarding behavior management. The following concerns were identified: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of the care plan showed the 12/24/22 plan for anti-psychotic use regarding behavior management included the following interventions regarding target behaviors: 1=anxiety, 2=agitation, 3=anger, 4=refusing assistance with cares. The interventions failed to individualize the behaviors, identify which staff members were required to assess those behaviors, how often the assessments were to be documented, and what was to be implemented if those behaviors were present. b. Interview with the DON on 2/8/23 at 10:11 AM confirmed the interventions on the care plan for the use of an anti-psychotic medication were non-specific, the plan was not individualized to identify target behaviors, how often they should be documented and by which staff members, and what staff were to do if the behaviors were present.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on medical record review, staff and resident interview, and policy and procedure review, the facility failed to ensure 1 of 5 sample residents (#1) reviewed for bowel management received the appropriate care and treatment to address constipation. This failure resulted in hospitalization and actual harm to the resident. The findings were: 1. Review of the 9/20/22 quarterly MDS assessment showed resident #1 was admitted to the facility on [DATE] with a diagnosis of cerebral palsy and had a BIMS score of 15/15 (cognitively intact). Further review showed the resident was always continent of bowel and required the extensive assistance of 2 or more staff members for toilet use and transfers. Review of the fluid maintenance care plan, last revised on 8/2/22, showed the resident was at risk for fluid maintenance issues related to impaired mobility, poor bowel regulation, history of urinary retention, and a history of constipation. The interventions included monitor bowel pattern to ensure [the resident] is having a regular bowel movement frequently that are soft and formed. Review of the medication administration record (MAR) showed the resident was prescribed psyllium husk powder (soluble fiber) every other day, for Bulk and regulate bowel movements with an order date of 5/19/21; bisacodyl (laxative) suppository, as needed, for 4 days with no bowel movement with an order date of 6/26/19; docusate sodium (laxative with stool-softening activity) capsule, as needed, every 12 hours for constipation with an order date of 1/6/20; an enema, as needed, for 5 days with no bowel movement with an order date of 6/26/19; Milk of Magnesia (laxative), as needed, for 3 days with no bowel movement with a start date of 6/26/19; MiraLax (laxative) powder, as needed, for constipation with an order date of 9/23/20; and Senna (laxative) tablet to be given every 24 hours, as needed, for constipation The following concerns were identified: a. Interview with the resident on 2/5/23 at 3:42 PM revealed s/he had been hospitalized for a bowel obstruction. The resident stated s/he attempted to hold in his/her bowel movements; however, was told by the physician that was not a good idea. An additional interview with the resident on 2/8/23 at 10:41 AM revealed s/he tried to hold in his/her bowel movements because the staff were slow to assist him/her and s/he did not want to be embarrassed. b. Review of the October 2022 bowel elimination documentation showed the resident had bowel movements (formed/normal; small in size) on 10/1/22 and on 10/6/22 (constipated/hard; large in size). The resident was given a bisacodyl suppository on 10/5/22 (day 4) which was noted as being semi-effective. Review of the October 2022 MAR showed no documentation the absence of a bowel movement had been addressed before day 4. c. Review of the October 2022 bowel elimination documentation showed the resident had bowel movements (constipated/hard; small in size) on 10/6/22 and on 10/11/22 (formed/normal; large in size). Review of the October 2022 MAR showed no documentation the absence of a bowel movement for 4 days had been addressed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	d. Review of the October 2022 bowel elimination documentation showed the resident's next bowel movement, from the 10/11/22 date, occurred on 10/19/22 (constipated: large in size). Review of a 10/16/22 at 7:59 AM nurse's progress note showed Resident reports no BM [bowel movement] in 4 days previous to this morning. Yesterday resident refused Metmucil stating [s/he] will go No BM yesterday. Resident refuses Miralax this morning. No PRN [as needed] order for the fiber [s/he] did not think [s/he] needed yesterday. MAC [certified medication aide] and this writer went over resident's PRN orders. [The resident] agreed to try a Senna (laxative), agreed that if there is no BM by this afternoon/before dinner [s/he] will take some warm prune juice with Miralax added. However, review of the October 2022 MAR showed no documentation Senna or any other PRN medication for constipation was administered at any time between 10/16/22 and 10/27/22. e. Review of the October 2022 bowel elimination documentation showed the resident had a bowel movement on 10/20/22 (constipated/hard; large in size). No other bowel movements were documented after 10/20/22. Review of a nurse progress note dated 10/27/22 and timed 5 AM showed Resident not feeling well. Emesis frequently. Abdomen sore and enlarged. Resident given suppository with no results .Bowel sounds diminished. Review of the October 2022 MAR showed no documentation the absence of bowel movement for 6 days had been addressed, and no documentation a suppository waa administered. f. Review of the medical record showed the resident was transferred to the hospital on 10/27/23. g. Review of the resident's Patient Discharge Instructions from the hospital, dated 10/30/22, showed the resident had diagnoses which included small bowel obstruction and constipation. 2. Interview with the DON on 2/7/23 at 2:41 PM revealed it was the facility's expectation the bowel protocol be followed. Further, the DON confirmed there was no further documentation and the resident's physician had not been notified. 3. Review of the Bowel Movement Protocol, revised November 2020, showed Day 3 of No Bowel Movement Milk of Magnesia Suspension 1200 MG/15ML-administer 30 Ml Q [every] 24 hours PRN [as needed] no bowel movement in three (3 days); Day 4 of No Bowel Movement Bisacodyl Laxative Suppository 10 MG-Administer One (1) Suppository rectally Q 24 hours PRN no Bowel Movement in four (4) days; Day 5 of No Bowel Movement Enema Ready-To-Use Rectal Enema 7-19 GM/118 ML-Administer one (1) enema @ 24 hour PRN no Bowel Movement in five (5) days. If previous interventions are not effective and resident has not had an adequately sized Bowel Movement contact primary care provider for further orders and advisement.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47344 Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to assess 1 of 2 sample residents (#277) who smoked for safety and level of supervision required. The findings were: 1. Review of the 1/31/23 admission MDS assessment showed resident #277 was admitted on [DATE] with diagnoses which included sepsis, chronic obstructive pulmonary disease, essential hypertension, need for assistance with personal care and dependence on supplemental oxygen. The resident had a BIMS score of 12 out of 15 indicating the resident was moderately impaired. Review of the 1/27/23 Nursing Admission Data Collection tool showed the resident was alert, used oxygen and did not use tobacco products. The following concerns were identified: a. Observation on 2/6/23 at 3:48 PM showed the resident went outside to smoke, escorted by the ADON after removing the resident's portable oxygen. b. Interview on 2/7/23 at 1:58 PM with the resident showed s/he had been smoking 3 times a day since s/he was admitted , and no one had interviewed her/him about her/his smoking habits. c. Interview on 2/7/23 at 2:17 PM with CNA #4 revealed the resident had been smoking at the facility since admission on 1/27/23. d. Interview on 2/7/23 at 4:29 PM with the ADON confirmed the facility failed to assess the resident for safety prior to smoking. e. Review of the medical record showed the facility failed to initiate a safe smoking evaluation prior to the surveyor's observation on 2/6/23. Further review failed to show safe smoking in the resident's care plan or any noted physician's consultation. f. Review of the 1/27/23 discharge note showed [S/He] does have a long history of smoking, currently 1.5 pack/day prior to admission. 2. Review of Smoking Policy- Residents last revised July 2017 showed 1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, . 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include .d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation).

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 38149 Based on observation, review of the nursing staff postings and staff interview the facility failed to ensure the daily staff information was in a prominent location; readily accessible to residents and visitors. Additionally the facility failed to include the actual hours worked on the on the daily staff postings. The census was 77. The findings were: 1. Observation at 6:30 PM showed the daily nursing staff posting was hanging by the employee time clock. Interview with the administrator at that time confirmed the nursing staff posting was usually hanging at the employee time clock which was not an area that was easily accessible to residents or visitors. 2. Review of the Daily Staff Posting from 1/1/23 to 1/31/23 failed to show the actual hours worked by the registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides responsible for resident care per shift. 3. Interview on 02/08/23 at 09:08 AM with the scheduler revealed she was not aware of the nurse staff information posting requirements. She confirmed the actual hours worked had not been posted for the resident care staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25745 Based on medical record review, staff interview, and policy review, the facility failed to ensure a monthly pharmacy drug regimen review was completed for 1 of 6 sample residents (#47) reviewed for medication irregularities. The findings were: Review of the 12/13/22 quarterly MDS assessment showed resident #47 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus II, anxiety disorder, and chronic obstructive pulmonary disease. The review showed the resident had a BIMS score of 7/15, indicating moderate cognitive impairment. The following issues were identified: a. Review of the physician orders showed the resident had an 8/25/22 order for Seroquel (anti-psychotic) 100 mg by mouth daily for anxiety due to a known physiological condition, and a clinical explanation provided on 2/7/23 by the pharmacist showed anxiety as a diagnosis was acceptable for the use of Seroquel related to the resident also taking sertraline (anti-depressant). b. Review of the 2/7/23 Medication Regimen Review, the only Medication Regimen Review provided, showed the pharmacist marked the following, A reduction would likely worsen or destabilize the resident's condition. Further review showed the physician had the following 3 options as a response: Agree, Disagree, or Other. The physician initialed below those choices and dated the recommendation for 2/7/23. However, the physician failed to select a choice, leaving the choice section blank. The Medication Review also failed to identify that no specific behaviors were identified and monitored. Review of the entire medical record showed pharmacy drug regimen reviews were not in the medical record. c. Interview with the DON on 2/8/23 at 9:52 AM showed there was a breakdown in the system regarding drug regimen reviews and a communication breakdown with the medical director. The facility failed to follow-up with the director and the facility was unsure where actual papers went. The facility had initiated a performance improvement project related to the failure. Review of the facility policy titled, Medication Regimen Reviews, last revised May 2019. The following statement was documented under Policy Statement; The consultant pharmacist reviews the medication regimen of each resident at least monthly. The following was documented under Policy Interpretation and Implementation, .12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. 38149

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25745 38149 Based on medical record review, facility policy review, and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 2 of 5 residents (#31, #47) reviewed. The findings were: 1. Review of the 12/31/22 quarterly MDS assessment for resident #31 showed diagnoses which included Parkinson's disease, neurocognitive disorder with Lewy bodies, dementia, and traumatic brain injury. Further review showed the resident received an antipsychotic on a daily basis. Review of the physician orders showed Olanzapine (antipsychotic) 5 milligrams (mg) was started on 9/21/21. The following concerns were identified: a Review of the 12/31/22 quarterly MDS assessment showed a gradual dose reduction (GDR) had not been attempted, nor was there physician documentation that a GDR was clinically contraindicated. b. Interview on 2/8/22 at 10:12 AM with the DON confirmed a GDR had not been attempted. c. Review of the Medication Regimen Review dated 2/7/23 showed a physician statement directing the facility continue the olanzapine at the current dose; however, a rationale for not implementing a GDR was not provided. 2. Review of the 12/13/22 quarterly MDS assessment showed resident #47 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus II, anxiety disorder, and chronic obstructive pulmonary disease. The review showed the resident had a BIMS score of 7/15, indicating moderate cognitive impairment. The following issues were identified: a. Review of the physician orders showed the resident had an 8/25/22 order for Seroquel (anti-psychotic) 100 mg by mouth daily for anxiety due to a known physiological condition, and a clinical explanation provided on 2/7/23 by the pharmacist showed anxiety as a diagnosis was acceptable for the use of Seroquel related to the resident also taking sertraline (anti-depressant). However; the review showed specific targeted behaviors were not documented. b. Review of the MARs for January and February 2023 showed the resident received Seroquel as ordered. The review of the MARs and TARs for January and February 2023 showed no specific targeted behaviors as being monitored related to the administration of Seroquel. c. Review of the nursing progress notes from 1/8/23 through 2/7/23 showed no behavioral symptoms were documented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Review of the care plan showed the 12/24/22 plan for anti-psychotic use regarding behavior management showed the following interventions regarding target behaviors: 1=anxiety, 2.=agitation, 3.=anger, 4=refusing assistance with cares. The interventions failed to individualize the behaviors, identify which staff members were required to assess those behaviors, how often the assessments were to be documented, and what was to be implemented if those behaviors were present. e. Interview with the DON on 2/8/23 at 10:11 AM confirmed specific behaviors were not being monitored related to the use of Seroquel. Interview with the DON on 2/8/23 at 9:52 AM revealed there was a breakdown in the system regarding drug regimen reviews and a communication breakdown with the medical director. The facility failed to follow-up with the director and the facility was unsure where actual papers went. The facility had initiated a performance improvement project related to the failure. Review of the facility policy titled, Medication Regimen Reviews, last revised May 2019. The following was documented under Policy Interpretation and Implementation, .9. An 'irregularity' refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38149 47344 Based on observation, staff interview, and policy review, the facility failed to secure medications when no authorized staff were present for 1 of 4 storage areas (Rock Creek/ East Hall) observed. The findings were: 1. Continuous observation on 2/7/23 from 7:40 AM to 7:45 AM of Rock Creek hall and medication cart showed the medication cart was unattended and unlocked (showing a red dot indicating the push lock was unlatched). RN #2 exited resident room [ROOM NUMBER] at 7:45 AM, and returned to the medication cart, and locked. Interview with the RN at that time revealed she was aware the medication cart should be locked when left unattended. 2. Review of the Storage of Medication policy, last revised November 2020, showed Unlocked medication carts are not to be left unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 25745 Based on observation, staff interview, review of the 2017 Food Code, and manufacturer's recommendations for use, the facility failed to ensure a sanitary environment in 1 of 1 food preparation areas, failed to ensure hair restraints were used during 2 random observations, and failed to ensure food was stored under safe conditions for 1 of 1 refrigerator/freezer observed outside of the kitchen area (Rock Creek Nurses Station). The findings were: 1. Regarding staff hygiene: a. Observation on 2/6/2022 at 8:45 AM in the Rock Creek dining room showed dietary aide #1 with a beard, blue mask and no beard hair net while serving the breakfast meal. b. Observation on 2/7/23 at 1:41 PM in the kitchen area, primarily in the dishwashing machine area, showed dietary aide #1 with a surgical mask on, and his beard was clearly observed hanging behind and below the mask without a cover. The dietary aide was handling clean dishes at that time. c. Interview on 2/7/23 at 2:05 PM with dietary aide #1 confirmed he routinely served breakfast at any one of the service areas. It was observed at that time he still had a beard showing without a cover. According to Food Code 2017, U.S. Public Health Service: 2-402.11 (A) .FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 2. Regarding unsanitary items in the kitchen prep area: a. Observation on 2/7/23 at 5:55 PM showed a Hessaire swamp cooler at the corner of the food preparation area that was visibly dark and soiled with debris; in particular, the filters on the right and left side were visibly darkened and soiled and were not clean. Opposite the Hessaire swamp cooler by the toaster area was an upright fan that was darkened and soiled with debris. Observation above the preparation area were 3 pipes across the kitchen and a half pipe for the sprinkler system that was visibly dirty and soiled. b. Interview with dietary aide #2 on 2/7/23 at 4:39 PM revealed the swamp cooler was used to cool off the kitchen when the kitchen became to warm to work. According to Food Code 2017, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the manufacturer's manual titled, Hessaire 1300 CFM Mobile Evaporative Cooler MC18 User Manual, dated November 6, 2021, documented under Operation Tips .Clean media pads and tank frequently. Under Cleaning Cooler & Rigid Media Pads: ws the following, The removeable panel(s) & pads can be gently sprayed off to remove build up. A soft bristle brush can also be used. 3. Regarding the tile floor in the kitchen and dishwashing machine area: a. Observation on 2/7/23 at 5:27 PM showed floor tiles were 1 foot by 1 foot in size, and 2 tiles to the left of the 3 compartment sink at the drain area were damaged, which collected darkened dirt and presented an uncleanable surface. Three floor tiles were damaged in front of the 2 door fridge in the panty area, which were darkened and presented an uncleanable surface. Damaged and mostly missing tiles under the dishwashing machine presented a darkened dirty area with an uncleanable surface. 4. Regarding storage of food: a. Observation on 2/5/23 at 4:20 PM of the Whirlpool refrigerator/freezer located behind the Rock Creek nurses' station showed a temperature log for the refrigerator; however, there was no documentation the temperature of the freezer was monitored. The freezer contained ice cream, popsicles, and candy bars. b. Observation on 2/5/23 at 4:20 PM of the Whirlpool refrigerator located behind the Rock Creek nurses' station showed 3 vanilla and 2 chocolate Mighty Shakes cartons. None of the cartons were marked with a thawed-on or use-by date. Review of the Mighty Shake carton showed Store frozen. Thaw under refrigeration. After thawing keep refrigerated and use within 14 days after thawing. b. Interview on 2/5/23 at 4:24 PM with CNA #1 confirmed the food in the refrigerator/freezer was for resident use. According to Food Code 2017, U.S. Public Health Service 4-204.112: (B) Except as specified in (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display. 5. Interview with the certified dietary manager (CDM) on 2/8/23 at 9:10 AM confirmed the Hessaire swamp cooler was dirty and not on a cleaning schedule. She further confirmed the upright fan and sprinkler system was not clean and not on a cleaning schedule. She stated her expectation was for any staff with a beard to have that beard completely covered, as well as hair. The CDM further confirmed she was unaware the freezer behind the Rock Creek Nurses Station had not been routinely temped, and was unaware of the Mighty Shakes being thawed without a thaw date documented on the cartons individually. She confirmed the damaged tiles on the floor presented an uncleanable surface, and had tried to have those repaired in the past. There was not a plan with a timeline to ensure those repairs. 37220

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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** 37220 Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection control practices were implemented for 4 random observations. The census was 77. The findings were: 1. Observation on 2/6/23 at 10:09 AM showed CNA #2 entered resident room [ROOM NUMBER] to obtain vital signs using a blood pressure cuff, oximeter, and a thermometer. The CNA exited resident room [ROOM NUMBER] and entered resident room [ROOM NUMBER] without cleaning the equipment between residents. Interview with the CNA at that time confirmed the equipment was not cleaned between residents. 2. Observations on 2/5/23 at 4:47 PM of resident dining showed LPN #2 obtained the blood glucose of a resident sitting at the dining table. The LPN failed to wear gloves while obtaining the blood glucose and no hand hygiene was observed after completion. Continued observation showed the LPN opened a medication bottle and inserted his ungloved finger inside the bottle to retrieve a pill from the bottle and no hand hygiene was performed. Interview with the LPN at that time confirmed he should have worn gloves and did not perform hand hygiene. 3. Observation on 2/7/23 at 7:45 AM showed RN #2 removed a bottle of enteric coated 81 milligrams of aspirin from the medication cart, pour the aspirin into her ungloved hand, and transfer the aspirin into a medication cup. In addition, RN #2 removed individual resident bubble packs from the medication cart, pushed the medication from the packs into her ungloved fingers, and transfer the medication into a medication cup. Interview with RN #2 at that time confirmed she had used her bare hands and fingers when transferring medication from one location to another. 4. Observation on 2/7/23 at 7:55 AM showed RN #1 used a cloth from a bleach disinfectant container to wipe down a pulse oximeter, a thermometer and a blood pressure cuff. The RN wiped the equipment down in less than 10 seconds. The label on the disinfectant container showed Disinfected in 4 minutes. Interview with the RN at that time confirmed the equipment dried in less than 4 minutes. She further stated she was not aware the equipment needed to stay wet for 4 minutes to obtain disinfection. 5. Interview on 2/7/23 at 3:23 PM with the infection preventionist revealed the expectation was to wear gloves when obtaining a blood glucose. He further stated the expectation was for staff to perform hand hygiene after obtaining a blood glucose, and while passing medications. Interview with the infection preventionist on 2/7/23 at 3:23 PM revealed the facility's expectation was for staff to follow the manufacturer's instruction for disinfection. 6. Review of the facility policy Obtaining a Fingerstick Glucose Level, with a revision date 10/11, showed . Steps in the Procedure .5. Wear clean gloves .20. wash hands . 7. Review of the Handwashing/Hand Hygiene policy, with a revision date 8/19 showed .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .c. before preparing or handling medications . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Review of the facility policy Cleaning and Disinfection of Resident-Care Items and Equipment, with a revision date 11/18 showed .4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions . 47344

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37220 Based on medical record review and staff interview, the facility failed to develop a procedure to ensure residents, who had consented to receive an immunization, received the vaccine for 1 of 5 residents (#36) reviewed for immunizations. The findings were: 1. Review of the Pneumococcal and Influenza Immunization Consent Form showed resident #36 consented to both the pneumococcal and influenza vaccine on 9/1/22. The following concerns were identified: a. Review of the medical record showed the resident had refused both the pneumococcal and influenza vaccines. b. Review of the Rock Creek vaccination worksheet, dated 10/18/22, showed the resident was sick at the time the vaccinations were given. A note on the worksheet revealed the resident wanted to be vaccinated when his/her current illness subsided. c. Interview with the infection preventionist on 2/8/23 at 8:39 AM confirmed the resident had not received the immunizations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 37220 Based on medical record review and staff interview, the facility failed to develop a procedure to ensure residents who had consented to receive the SARs-COV-2 vaccine/booster received the immunization for 1 of 5 residents (#14) reviewed. The findings were: 1. Review of the SARs-COV-2 education and consent form showed resident #14 had consented to receive the vaccination on 10/7/22. The following concerns were identified: a. Review of the facility's resident vaccination records received from the facility on 2/6/23 showed the resident was unvaccinated. b. Interview with the infection preventionist on 2/8/23 at 8:39 AM confirmed the resident had not received the vaccination and he was unable to locate any further documentation.