STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035286	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sante of North Scottsdale	17490 North 93rd Street Scottsdale, AZ 85255

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one Resident # 42 was informed of the risks and benefits related to use of psychotropic medication for one resident (#42). The deficient practice could result in residents not having the choice to refuse proposed treatment plans as well as to be informed of potential adverse side effects of receiving psychotropic medications. Findings include: Resident #42 was admitted on [DATE] with diagnoses that included urinary tract infection (UTI), severe sepsis without septic shock, and acute respiratory failure with hypoxia. A physician order dated September 2, 2024 included for Mirtazapine (antidepressant) 15 mg (milligram), to give 1 tablet by mouth at bedtime for depression as evidenced by verbalization of sadness. A review of the MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 10 indicating the resident had moderate cognitive impairment. A nurse practitioner note dated September 5, 2025 revealed that the resident had Mirtazapine 15 mg as current psychiatric medication; and that, the resident was unaware of the current medication. Review of medication administration records (MAR) for September 2024 revealed that Mirtazapine was documented as administered from September 2 through September 11, 2024. Despite documentation that resident was receiving Mirtazapine, there was no evidence found in the clinical record that the resident was informed of the risk and benefits for the use of Mirtazapine. An interview was conducted on September 12, 2024 at 8:58 a.m. with the MDS Coordinator (Staff #28) who stated that resident #42 was started on an anti-depressant on September 2, 2024. The MDS coordinator stated that she was unable to find that the risks and benefits related to Mirtazapine was explained to the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Director of Nursing (DON/staff #66) was conducted on September 12, 2024 at 9:09 a.m. The DON stated that the clinical record revealed no documentation that explained the risks and benefits for the use of Mirtazapine was found in the clinical record for resident #42. The DON stated that Mirtazapine was ordered for resident #42 on September 2, 2024 and did not have an end date. The Director of Health Information (DHI/staff #163) joined the interview and stated that there was no consent form that explained the risks and benefits for the use of Mirtazapine found in the clinical record. In another interview conducted with the DON on September 12, 2024 at 9:27 a.m., the DON stated that the purpose of a consent was make the residents aware of the treatment and side effects of the psychotropic medication. The DON stated that there was no documentation that the risks and benefits for the use of Mirtazapine were explained prior to its administration for Resident #42. Further, the DON stated that this did not meet the facility's expectations. An interview with resident #42 was conducted on September 12, 2024 at 9:50 a.m. The resident stated that he make his own choices and he was not aware that he was taking Mirtazapine or any anti-depression medications. Review of the facility's policy on Resident Rights, revised on December 2016, revealed that federal and state laws guarantee certain basic rights to all residents of this facility; these rights include the resident's right to: be informed of, and participate in, his or her care planning and treatment.

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, clinical record review, interviews, and facility policy review, the facility failed to ensure that communication deficit was addressed with interventions to accommodate needs and abilities for one resident (#327) . The sample size was one of one. The deficient practice could result in a care plan that did not meet the resident's needs. Findings Include: Resident #327 was admitted on [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis affecting the right side, and encephalopathy. The hospital speech therapy note dated August 27, 2024 revealed that the resident had impaired cognition, dysphagia (swallowing disorder), and dysarthria (speech disorder); and that, the resident had moderate dysarthria impacting overall intelligibility at conversational level. Strategies included were for the resident to slow rate of speech and over-articulate sound to improve intelligibility. The hospital discharge instructions dated September 3, 2024 revealed that discharge diagnoses of stroke, right hemiplegia, dysarthria, and dysphagia. The admission evaluation summary dated September 3, 2024 included the resident was admitted for acute encephalopathy, CVA (cardiovascular accident), dysphagia and weakness. Per the documentation, the resident was able to complete simple commands, best verbal response was oriented and appropriate, and, was capable of voicing like/dislikes and preferences for meal choices. It also included that ability to hear was adequate (with hearing aid or hearing appliances if normally used) and there was no hearing aid or other hearing appliance used while determining hearing abilities. Further, the documentation included that the resident was understood when expressing ideas and wants, using verbal and non-verbal expression, understands verbal content and speech pattern was clear. The inventory sheet dated September 3, 2024 revealed no evidence of glasses, hearing aids, or dentures listed as the resident's belongings on admission. A physician order dated September 3, 2024 included for speech therapy evaluation, screening, and treatment A speech therapy evaluation completed by speech therapist (ST/staff #113) and signed on September 4, 2023 revealed the resident had moderate dysarthria, dysphagia, cognitive impairment, visual deficits on the right side, was very hard of hearing and required increased volume. The evaluation included that the resident's ability to express ideas and wants was documented as sometimes understood. Per the documentation, the resident's speech intelligibility at the short phrase level was 50%; and, identified a short-term goal for resident to demonstrate 75% speech intelligibility at the short phrase level to better communicate her wants, needs, pain and medical situation. Approaches may include treatment of speech, language, voice, communication, and/or auditory processing. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The baseline care plan initiated September 4, 2024 revealed the resident had a self-care deficit as evidenced by the need for assistance with ADLs (activities of daily living) related to age, limited mobility, CVA, right hemiplegia, dysphagia and cognitive impairment. Interventions included 1-2 staff participation with ADLs. The admission MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 7 indicating the resident had severe cognitive impairment. The assessment coded the resident had adequate hearing, no difficulty in normal conversation, social interaction, listening to TV; and, had no hearing aid. It also included that the resident had clear speech, defined as distinct intelligible words; the ability to express ideas and wants was coded as understood; and, the ability to understand others was coded as understands - clear comprehension. Despite coding this information, the resident was coded as rarely/never understood and family/significant other not available in another section of the MDS. Review of the updated care plan revealed initiated on September 11, 2024 revealed the resident was at risk for miscommunication due to dysarthria, cognitive deficits, and hard of hearing. Goals included that the resident will be able to make basic needs known on a daily basis and have improved communication with others, understanding others, engaging in every day decision making. Interventions included to allow the resident time to express thoughts and feelings, use communication techniques which enhance interaction, allow adequate time to respond, repeat as necessary, do not rush, request feedback, clarification from the resident, to ensure understanding, face when speaking and make eye contact, turn off TV/radio as needed to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use effective strategies such as touch, facial expression, eye contact, gestures, tone of voice, non-threatening posture, short direct phrases, speak slowly, speak in a calm, distinct manner, time to communicate, 1:1 quiet setting for communicating with resident, encourage resident to continue stating thoughts even if resident is having difficulty, and focus on a word or phrase that makes sense, or respond to the feeling resident is trying to express. An observation and attempted interview with resident #327 conducted on September 9, 2024 at 10:05 a.m. revealed the resident laying in the bed in her room, had no teeth, verbalizing phrases with very slurred speech and was very difficult to understand. There was no evidence of any communication devices, such as whiteboard with pen found in the room. During the attempts to communicate, the resident repeatedly motioned with her hand toward her ear indicating what appeared to be an attempt to communicate to come closer and speak louder. An interview with a certified nurse assistant (CNA/staff #24) conducted on September 11, 2024, at 7:48 a.m., the CNA stated that he had just worked with the resident was weak on one side, had slurred speech, and was difficult to understand. He stated that he was not sure if the resident had normal hearing. The CNA stated that he had to ask the resident leading yes' or no questions to understand what the resident was saying. Further, the CNA stated that if the resident were to say a full sentence that he would not be able to understand her. The CNA said that he was not sure whether any of the nurses or therapists had put in place any communication recommendations for the resident; but, using a whiteboard would help with individuals like the resident. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview conducted with the ST (staff #113) on September 11, 2024, at 7:52 a.m., the ST stated that resident #327 had an extremely bad hearing problem, a visual field cut, and the biggest issue was her speech intelligibility. The ST stated that she was working on the resident's communication with various interventions; and, she was using the whiteboard which was in the resident's room at bedside. The ST stated that she had let had let nursing know to use the whiteboard, to let the resident see their face and speak slowly. The ST stated that she was not involved in creating or revising the care plan of a resident; but she writes/revises orders and communicates verbally with the nursing staff. Furthermore, the ST stated that the risk for a resident who was unable to effectively communicate with staff was that the resident cannot express how they are feeling or may not be able to follow instructions, which could lead to a missed injury or contribute to falls. An interview with the Director of Rehab (Staff #145) was conducted on September 11, 2024 at 8:22 AM. The director of rehab stated that her expectation was that the information on communication issues were communicated by a therapist to a nurse to be added to the resident's care plan; and that, items that should be on the care plan include communication issues with hearing or speech, and identify if someone uses a whiteboard. In an interview with the MDS coordinator/Staff #28) conducted on September 11, 2024, at 8:35 a.m., the MDS coordinator stated that while conducting her portions of the MDS assessment, she recalled that resident #327 had clear speech and coded her as such on the MDS assessment. However, later in the interview, the MDS coordinator stated that the resident's communication took a lot of time and that the resident was in and out of clear speech. The MDS coordinator also said that for a resident who have a diagnosis of dysarthria there should be care plan related to communication. The MDS coordinator stated that there would be no risk of harm to a resident who could not effectively communicate their needs to staff, because the residents get checked on. An interview with the Director of Nursing (DON/staff #66) was conducted on September 11, 2024, at 9:00 AM. The DON stated that resident #327, the DON stated that she did not see anything about the resident's hard of hearing and communication problem in the resident's care plan. The DON further stated that there could be risk for harm if a resident was not able to communicate effectively. An interview with the administrator (staff #143) was conducted on September 11, 2024. The Administrator stated that staff does not have a problem communicating with Resident #327. In another observation conducted on September 12, 2024 at 9:20 a.m., the resident in the bed in her room, attempting to communicate with very slurred speech, and was pointing to her mouth and to the juice cup on the bedside table while attempting to communicate. There were no communication devices such as a whiteboard with pen to use to assist in communicating with the resident. A CNA (staff #24) joined in the observation; and, the CNA had difficulty understanding what the resident was saying; and, had to repeat questions and increase the volume of his voice. Multiple attempts to communicate revealed that the resident was repeating a phrase; and, the only part of her speech that was understandable was the word medication. The CNA then stated that the resident was saying that they gave her medication in her cup. The CNA then exited the resident's room. Staff #24 then left the room with no further conversation; and, shortly thereafter, the ST (staff #113) entered the room and closed the door. Another observation was conducted on September 12, 2024 at 10:04 a.m. revealed the ST (staff #113) leaving the resident's room, and the resident had a whiteboard in her hand. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A follow-up observation was conducted on September 13, 2024 at 8:57 AM. During the observation a CNA (staff#62) attempted to speak with resident #327 while the resident was in bed in her room. The CNA asked the resident multiple times whether the resident was ready to eat because the resident did not respond to the question. The CNA then raised the volume of her voice volume then the resident was able to hear and responded yes. In an interview on September 12, 2024, at 9:32 a.m., a nurse practitioner (NP/Staff#18) stated that she was familiar with resident #327 and, it was difficult to understand the resident because the resident had no teeth and had a stroke. The NP further stated that the resident was better with yes/no questions, but not full sentences. An interview with another CNA (staff #62) was conducted on September 13, 2024 at 8:57 a.m. The CNA stated that the resident was hard of hearing; and, the resident was able to hear when staff would raise their voice louder. Review of the facility's policy titled Care of Visually Impaired Resident revised February 2018 revealed that when interacting with the visually impaired resident, staff will: -Use the resident's name when speaking to him/her so he/she will know you are speaking to him/her. -Assist with ADLs as needed or requested. -Let the resident know when you leave the room. -Use large lettering on any distributed written information. -Attempt to keep the environment consistent by leaving objects in their designated locations. Review of the facility's policy titled Care of Hearing Impaired Resident revised February 2018 revealed that when interacting with the hearing impaired or deaf resident, staff will: -Evaluate the resident's preferred method of communication (signing, lip reading, tablet, etc.) with staff and other residents. -Determine the resident's awareness of and adaptation to hearing loss. -Regularly engage the resident in conversation using whatever communication method he or she prefers. -Directly face the resident when speaking so he/she can follow facial expressions and lip read, if possible. -Provide pencil and paper or tablet to communicate in writing, if the resident is able.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on observations, clinical record review, interviews, and facility policy review, the facility failed to ensure that one resident's (#327) communication deficit was addressed in the baseline care plan. The sample size was one of one. The deficient practice could result in a care plan that did not meet the resident's needs. Findings Include: Resident #327 was admitted on [DATE] with diagnoses of cerebral infarction, hemiplegia and hemiparesis affecting the right side, and encephalopathy. The hospital speech therapy note dated August 27, 2024 revealed that the resident had impaired cognition, dysphagia (swallowing disorder), and dysarthria (speech disorder); and that, the resident had moderate dysarthria impacting overall intelligibility at conversational level. Strategies included were for the resident to slow rate of speech and over-articulate sound to improve intelligibility. The hospital discharge instructions dated September 3, 2024 revealed that discharge diagnoses of stroke, right hemiplegia, dysarthria, and dysphagia. The admission evaluation summary dated September 3, 2024 included the resident was admitted for acute encephalopathy, CVA (cardiovascular accident), dysphagia and weakness. Per the documentation, the resident was able to complete simple commands, best verbal response was oriented and appropriate, and, was capable of voicing like/dislikes and preferences for meal choices. It also included that ability to hear was adequate (with hearing aid or hearing appliances if normally used) and there was no hearing aid or other hearing appliance used while determining hearing abilities. Further, the documentation included that the resident was understood when expressing ideas and wants, using verbal and non-verbal expression, understands verbal content and speech pattern was clear. The inventory sheet dated September 3, 2024 revealed no evidence of glasses, hearing aids, or dentures listed as the resident's belongings on admission. A physician order dated September 3, 2024 included for speech therapy evaluation, screening, and treatment A speech therapy evaluation completed by speech therapist (ST/staff #113) and signed on September 4, 2023 revealed the resident had moderate dysarthria, dysphagia, cognitive impairment, visual deficits on the right side, was very hard of hearing and required increased volume. The evaluation included that the resident's ability to express ideas and wants was documented as sometimes understood. Per the documentation, the resident's speech intelligibility at the short phrase level was 50%; and, identified a short-term goal for resident to demonstrate 75% speech intelligibility at the short phrase level to better communicate her wants, needs, pain and medical situation. Approaches may include treatment of speech, language, voice, communication, and/or auditory processing. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The baseline care plan initiated September 4, 2024 revealed the resident had a self-care deficit as evidenced by the need for assistance with ADLs (activities of daily living) related to age, limited mobility, CVA, right hemiplegia, dysphagia and cognitive impairment. Interventions included 1-2 staff participation with ADLs. The admission MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 7 indicating the resident had severe cognitive impairment. The assessment coded the resident had adequate hearing, no difficulty in normal conversation, social interaction, listening to TV; and, had no hearing aid. It also included that the resident had clear speech, defined as distinct intelligible words; the ability to express ideas and wants was coded as understood; and, the ability to understand others was coded as understands - clear comprehension. Despite coding this information, the resident was coded as rarely/never understood and family/significant other not available in another section of the MDS. Despite documentation that the resident had communication difficulties, there was no evidence found that a baseline care plan was developed with goals and interventions implemented to address this until September 11, 2024. Review of the updated care plan revealed initiated on September 11, 2024 revealed the resident was at risk for miscommunication due to dysarthria, cognitive deficits, and hard of hearing. Goals included that the resident will be able to make basic needs known on a daily basis and have improved communication with others, understanding others, engaging in every day decision making. Interventions included to allow the resident time to express thoughts and feelings, use communication techniques which enhance interaction, allow adequate time to respond, repeat as necessary, do not rush, request feedback, clarification from the resident, to ensure understanding, face when speaking and make eye contact, turn off TV/radio as needed to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use effective strategies such as touch, facial expression, eye contact, gestures, tone of voice, non-threatening posture, short direct phrases, speak slowly, speak in a calm, distinct manner, time to communicate, 1:1 quiet setting for communicating with resident, encourage resident to continue stating thoughts even if resident is having difficulty, and focus on a word or phrase that makes sense, or respond to the feeling resident is trying to express. An observation and attempted interview with resident #327 conducted on September 9, 2024 at 10:05 a.m. revealed the resident laying in the bed in her room, had no teeth, verbalizing phrases with very slurred speech and was very difficult to understand. There was no evidence of any communication devices, such as whiteboard with pen found in the room. During the attempts to communicate, the resident repeatedly motioned with her hand toward her ear indicating what appeared to be an attempt to communicate to come closer and speak louder. An interview was conducted on September 11, 2024, at 7:21 AM, with a certified nursing assistant (CNA/staff #24) who stated that he was assigned to the resident #327's room; and, that, that this was his first shift working with the resident. He also stated that he was not familiar with the resident care; and, he could find out details on how to care for the resident in the care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview with the CNA (staff #24) conducted on September 11, 2024, at 7:48 a.m., the CNA stated that he had just worked with the resident was weak on one side, had slurred speech, and was difficult to understand. He stated that he was not sure if the resident had normal hearing. The CNA stated that he had to ask the resident leading yes' or no questions to understand what the resident was saying. Further, the CNA stated that if the resident were to say a full sentence that he would not be able to understand her. The CNA said that he was not sure whether any of the nurses or therapists had put in place any communication recommendations for the resident; but, using a whiteboard would help with individuals like the resident. In an interview conducted with the ST (staff #113) on September 11, 2024, at 7:52 a.m., the ST stated that resident #327 had an extremely bad hearing problem, a visual field cut, and the biggest issue was her speech intelligibility. The ST stated that she was working on the resident's communication with various interventions; and, she was using the whiteboard which was in the resident's room at bedside. The ST stated that she had let had let nursing know to use the whiteboard, to let the resident see their face and speak slowly. The ST stated that she was not involved in creating or revising the care plan of a resident; but she writes/revises orders and communicates verbally with the nursing staff. Furthermore, the ST stated that the risk for a resident who was unable to effectively communicate with staff was that the resident cannot express how they are feeling or may not be able to follow instructions, which could lead to a missed injury or contribute to falls. An interview with the Director of Rehab (Staff #145) was conducted on September 11, 2024 at 8:22 AM. The director of rehab stated that therapy staff should notify nursing for creating/revision of care plans for any therapy recommendations. Additionally, the director of rehab said that the therapists would notify her and she would then relay that information to nursing. Staff #145 stated that neither she nor the therapists were involved with directly adjusting the care plan; and that, the nursing team was responsible for creating/revising the care plan. Staff #145 stated that it was her expectation that the information on communication issues were communicated by a therapist to a nurse to be added to the resident's care plan; and that, items that should be on the care plan include communication issues with hearing or speech, and identify if someone uses a whiteboard. In an interview with the MDS coordinator/Staff #28) conducted on September 11, 2024, at 8:35 a.m., the MDS coordinator stated that while conducting her portions of the MDS assessment, she recalled that resident #327 had clear speech and coded her as such on the MDS assessment. However, later in the interview, the MDS coordinator stated that the resident's communication took a lot of time and that the resident was in and out of clear speech. The MDS coordinator also said that for a resident who have a diagnosis of dysarthria there should be care plan related to communication. The MDS coordinator stated that there would be no risk of harm to a resident who could not effectively communicate their needs to staff, because the residents get checked on. An interview with the Director of Nursing (DON/staff #66) was conducted on September 11, 2024, at 9:00 AM. The DON stated that the resident's baseline care plan was based on the needs of each resident; and, should include things like nutrition, elimination, and medical diagnoses. The DON stated that the baseline care plan should also include if the resident speaks another language or has a communication problem. Regarding resident #327, the DON stated that she did not see anything about the resident's hard of hearing and communication problem. The DON further stated that there could be risk for harm if a resident was not able to communicate effectively. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the administrator (staff #143) was conducted on September 11, 2024. The Administrator stated that staff does not have a problem communicating with Resident #327. Review of the facility's policy titled Care Plans-Baseline revised March, 2022 revealed that a baseline care plan to meet the resident's immediate and safety needs is developed for each resident within forty-eight hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: -Initial goals based on admission orders and discussion with the resident/representative; -Physician orders; and, -Therapy services. Furthermore, the policy stated that the baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed.

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Sante of North Scottsdale	17490 North 93rd Street Scottsdale, AZ 85255

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on clinical record review, interviews, and policy review, the facility failed to ensure medications were administered as ordered for two of 17 sampled residents (#272 and #277). The deficient practice could result in resident not receiving the required treatment they need. The facility census was 69. Findings include: -Resident #272 was admitted on [DATE] with diagnoses of Covid-19, [NAME]-[NAME] Virus (EBV), Cytomegalovirus (CMV), myelodysplastic syndrome, bone marrow transplant status, and metabolic encephalopathy. A physician order dated 11/16/23 included for Maribavir (antiviral) 200 mg (milligram) give two tablets of twice a day for history of EBV/CMV viremia. Review of the electronic Medication Record (eMAR) note dated 11/17/23 included that Maribavir was not given because staff were waiting for the Maribavir to be brought in from resident's home. The Nurse Practitioner progress note dated 11/18/23 revealed the resident was on Maribavir due to history of EBV and CMV. An eMAR note dated 11/18/23 nurse note revealed that the prescribed Maribavir 200 mg tablet was not given because the medication was pending pharmacy delivery. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident had intact cognition. The eMAR note dated 11/27/23 revealed clinical staff were awaiting receiving Maribavir Oral Tablet 200 mg from the pharmacy as reason for dose was not given. There was no evidence found in the clinical record that the physician was notified that the resident was not administered Maribavir as ordered on 11/17, 11/18 and 11/27/2023. An interview with the resident's family was conducted on 9/9/2024 at 4:36 p.m. The family stated that on 12/5/2023, the spouse requested the nurse on duty to return the transplant research drugs that were bought from home. The family stated that she saw a fully sealed unopened bottle of Maribavir with a note she wrote still attached to it on the nurse medication cart. The family further stated that the medication was given back to them over a week ago, still sealed and unopened; and that, the resident never received Maribavir. In an interview conducted with administrator on 9/12/2024 at 2:37 p.m., the administrator stated that there was no documentation found in the clinical record why Maribavir was not administered as ordered to resident #272 on 11/17, 11/18 and 11/27/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted was conducted on 9/13/2024 at 11:45 a.m. with the Director of Nursing (DON) who stated that there was no documentation found in the clinical record why Maribavir was not administered as ordered to resident #272 on 11/17, 11/18 and 11/27/2023. -Resident #277 was admitted on [DATE] with diagnoses of paroxysmal atrial fibrillation, presence of cardiac pacemaker, Type 2 diabetes, bradycardia, and long-term use of anticoagulants. The MAR for April 2024 revealed that Afrin Original Nasal Spray (nasal decongestant) was not documented as administered on 4/22, 4/23/, 4/24 and 4/25/2024 The eMAR note dated 4/22/2024 included that Afrin Original Nasal Solution was not found in the cart. Review of Order Audit Report dated 4/23/2024 revealed Afrin 12 Hour Nasal Solution 0.05% status was On Order status. The eMAR note dated 4/23/2024 revealed the medication was not available due to awaiting pharmacy delivery. Despite documentation that the Afrin was not administered as ordered, there was no evidence the provider was notified until 4/24/2024. The eMAR note dated 4/24/2024 included that Afrin 12 Hour Nasal Solution 0.05% was not available; and that, the provider was aware and the medication will be put on hold. A physician order dated 4/24/2024 revealed a hold order for Afrin. A note dated 4/24/24 included that the medication was not available and but awaiting pharmacy delivery. An eMAR note dated 4/25/24 revealed that the medication was not on hand, and it was on order. A physician progress note dated 4/25/24 included that on 4/23/24 Eliquis (a blood thinner) was on hold for 3 days; and, to give 1 large spray in each nostril of Afrin three times a day. Per the documentation, Eliquis continued to be on hold for one more day because facility was still awaiting Afrin delivery. An interview with the resident's representative (RR) was conducted on 9/12/24 at 12:50 p.m. The RR voiced concerns about the resident's nosebleeds over the past five days due to the nasal cannula become blocked with blood. The RR stated that the facility never gave the spray to the resident because the facility does not keep it on hand; and that, nobody relayed this to the provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Licensed Practical Nurse (LPN/staff #161) on 9/12/2024, The LPN stated that possible complication of missing doses of a blood thinner can increase the risk of blood clots in a patient. The LPN stated that staff monitor for patient on blood thinners constantly, looking for signs that include excessive bleeding and bruising, blood in urine and stool; and that, signs of a blood clot can include shortness of breath, and changes in mental status. The LPN said that any abnormal finding is immediately reported to the nurse in charge and provider. The LPN also said that when obtaining hold orders for medications, the provider was contacted with the nurse's or resident's concern; and that, the provider will make the decision on whether or not to grant the hold order. An interview conducted with administrator (staff #143) on 9/12/24 at approximately 2:50 p.m., the administrator provided documentation to support the hold order for Afrin on 4/24/2024. However, the administrator stated there was no documentation found in the clinical record that Afrin was placed on hold and the provider was notified on 4/22 and 4/23/2024 when it was documented in the clinical record as not administered. In an interview with the DON (staff #65) conducted on 9/13/2024 at 11:45 a.m., the DON stated that there was no documentation found in the clinical record that Afrin was placed on hold and the provider was notified on 4/22 and 4/23/2024 when it was documented in the clinical record as not administered. The DON further stated that nursing staff were to communicate with the provider and properly document all hold orders for any medications. The facility policy on Administering Medications included that medications shall be administered in a safe and timely manner and as prescribed. It also included that medications must be administered in accordance with the orders, including any required timeframe. The facility policy on Medication Shortages/Unavailable Medications included that the facility should obtain alternate Prescriber orders, as necessary. It also included that if the facility nurse is unable to obtain a response from the prescriber in a timely manner, the facility nurse should notify the nursing supervisor and medical director for alternate orders/directions.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that opioid medication orders for two residents (Resident #4 and #38) were administered following the physician ordered parameters. The deficient practice could result in inaccurate administration of opioid medication, with the potential of over medicating resident's with opioid medication. Findings include: -Resident #4 was admitted on [DATE] with diagnoses of fibromyalgia and generalized anxiety disorder. A review care plan dated August 9, 2024 revealed the resident had fibromyalgia, arthritis and chronic back pain. Intervention included to administer medications and treatment as ordered. The physician progress note dated August 15, 2024 included assessments of bilateral hip osteoarthritis, left hip pain, lumbar and thoracic spondylosis and degenerative disc disease, and fibromyalgia. Recommendations included that the resident had Norco (narcotic opioid) 1 tablet every 4 hours as needed for pain; and would recommend scheduling Tylenol (analgesic) 650 mg (milligrams) three times daily to help reduce basal level of pain to help reduce the amount of Norco needed. The physician order dated September 9, 2024 revealed an order for hydrocodone-acetaminophen (narcotic/opioid medication) 5/325 mg one tablet by mouth every eight hours for a pain level of 6 - 10. This order was transcribed onto the MAR (medication administration record) for September 2024. Review of the MAR for September 2024, revealed the resident hydrocodone-acetaminophen on September 3 for a pain level of '0'; and, on September 8 for a pain level of 5. The clinical record revealed no documentation of a reason why the medication was administered outside of the ordered parameter; and that, the physician was notified. An interview with a licensed practical nurse (LPN/staff #138) conducted on September 13, 2024 at 10:30 a.m. The LPN stated that the clinical record revealed that hydrocodone-acetaminophen medication was administered outside of the physician ordered pain parameters on September 3 and 8, 2024. During an interview with a Director of Nursing (DON) conducted on September 13, 2024 at 10:54 a.m., the DON stated that hydrocodone-acetaminophen was administered outside of the ordered parameters on September 3 and 8, 2024. 51103 -Resident #38 was admitted on [DATE] with the diagnoses of anterior soft tissue impingement, pain aggravated by activities of daily living, muscle stiffness and weakness, and other abnormalities of gait and mobility. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician order dated August 22, 2024 included pain evaluation every shift. The care plan initiated on August 23, 2024 included a goal for the resident's pain and discomfort to not interrupt their daily routine. The admission MDS assessment dated [DATE] revealed a BIMS score of 14 indicating that the resident had intact cognition. The physician order dated August 28, 2024 revealed oxycodone (narcotic opioid) 5 mg two tablets by mouth every 4 hours as needed for pain 6-10. A review of the pain and palliative care progress note dated August 28, 2024 revealed the goal for treatment was to titrate medications to lowest effective dosing required for pain control; and that, a realistic pain goal of 3-4 out of 10 was identified. The order for oxycodone was transcribed onto the MAR for August and September 2024. Review of the MAR for August and September 2024 revealed that oxycodone was administered outside of the physician ordered parameters on the following dates: -August 30 for pain level of 4; -September 2 at 12:13 p.m. for pain level of 4; -September 2 at 5:01 p.m. for pain level of 4; -September 4 at 11:22 a.m. for pain level of 4; -September 4 at 3:27 p.m. for pain level of 4; -September 5 at 8:54 a.m. for pain level of 5; -September 5 at 2:17 p.m. for pain level of 2; -September 9 at 11:22 a.m., for pain level of 0; -September 10 at 4:49 a.m., for pain level of 5; -September 11 at 7:49 a.m. for pain level of 2; and, -September 12 at 2:13 p.m. for pain level of 5. The clinical record revealed no evidence why the resident received the medication outside of the physician ordered pain parameters; and that, the provider was notified. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with certified nurse assistant (CNA/staff #4) conducted on September 9, 2024 at 2:04 p.m., the CNA stated that when a resident complains of pain, the CNAs would do their best to make the resident comfortable, and immediately report to the nurse. The CNA stated that signs/symptoms that a resident was overmedicated included nausea, dizziness, weakness, and increased sleepiness. The CNA said that when staff work with the resident's enough, staff better know what was normal for that resident. The CNA also said that the CNAs do not have control on wait times related to medication administration. In an interview conducted with resident #38 on September 10, 2024 at 2:54 p.m., the resident stated she had issues with severe itching and pain; and that, the physician told her that the cause of itch was due to the prescribed Oxycodone. The resident stated that her current pain level was at a 5 on a scale of 0-10.; however, the pain last night was between 7-8 and was worse because of the itching. Further, the resident stated that her pain medications were not being administered on time. The resident stated her pain medication was supposed to be given every 4 hours, but sometimes they come one to four hours later after requested. Further, the resident stated that staff become irritated when pain medication was requested. In an interview with a licensed practical nurse (LPN/staff #28) conducted on September 11, 2024 at 7:50 a.m. , the LPN stated that before pain medications are administered to the resident; the resident's pain levels, level of consciousness, and general condition were evaluated. The LPN said that staff need to follow the parameters set for drug administration; otherwise, it can cause injury to the resident. In an interview with the administrator conducted on September 12, 2024 at approximately 2:30 p.m., the administrator stated that based on the clinical record, pain medication for resident #38 was administered outside of the physician ordered-parameters; and this did not meet facility expectations and policy. The revised December 2012 policy entitled Administering Medications revealed that the administration of medications must be administered in accordance with the resident's order, including any required time frame. In addition, the policy further advises that if the doses are inappropriate or excessive the nurse should contact the resident's provider or medical director to discuss the concerns. The revised October 2010 policy entitled Administering Pain Medications stated that residents are not at risk for addiction to narcotic analgesics if used as prescribed for moderate to severe pain. The policy further provides guidelines for assessing the resident's level of pain prior to administering analgesic pain medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49325 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure target behaviors, side effects and effectiveness related to psychotropic medications were monitored for three residents (#42, #1 and #23). The sample size was 6. The deficient practice could result in complications. Findings include: -Resident # 42 was admitted on [DATE] with diagnoses of urinary tract infection (UTI), severe sepsis without septic shock, and acute respiratory failure with hypoxia. A physician order dated September 2, 2024 included for Mirtazapine (antidepressant) 15 mg (milligram), to give 1 tablet by mouth at bedtime for depression as evidenced by verbalization of sadness. A review of the MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 10 indicating the resident had moderate cognitive impairment. A nurse practitioner note dated September 5, 2025 revealed that the resident had Mirtazapine 15 mg as current psychiatric medication; and that, the resident was unaware of the current medication. Assessment included anxiety disorder. The care plan dated September 6, 2024 included the resident used an antidepressant medication Mirtazapine related to depression as evidenced by verbalization of sadness. Interventions included to administer antidepressant medications ordered by the physician and monitor/document side effects and effectiveness. Review of medication administration records (MAR) for September 2024 revealed that Mirtazapine was documented as administered from September 2 through September 8, 2024. Despite documentation that medication was administered, there was no evidence that the resident was monitored for side effects and effectiveness of the antidepressant from September 2 through September 8, 2024. A physician order dated September 9, 2024 included an order to observe resident closely for significant side effects related to atypical antidepressant use and report to the physician. An interview was conducted on September 12, 2024 at 8:58 a.m. with the MDS coordinator (staff #28) who stated that the resident was started on an anti-depressant on September 2, 2024; and that, she was unable to find a diagnosis of depression for resident #42. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Director of Nursing (Staff # 66) was conducted on September 12, 2024 at 9:09 a.m. The DON stated that there were no diagnoses of depression for resident #42; and that, the scheduled psychotropic medication, Mirtazapine was ordered on September 2, 2024 for resident #42 and did not have an end date. The DON stated that based on the clinical record, there was no evidence that monitoring behavior and side effects was conducted/completed until September 9, 2024. The DON stated there was a risk of not knowing any side effects related to this medication because it was not monitored. Further, the DON stated that this did not meet the facility's expectations. 51124 -Resident #1 was admitted on [DATE], with diagnoses that included anxiety disorder, and major depressive disorder. A review of the admission MDS (minimum data set) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS also was coded that the resident felt down, depressed, or hopeless several days over the past two weeks. Review of the physician order dated August 28, 2024 included to monitor for presence or absence of behavioral expressions as evidenced by anxiety as evidenced by restlessness at the time of evaluation for Lorazepam (antianxiety) use, every day and night shift. A physician order dated August 30, 2024 included for Ativan (brand name for Lorazepam) give 0.5 mg (milligram) tablet every 8 hours as needed for anxiety as evidenced by restlessness. Discontinue date of September 5, 2024. A physician order dated September 5, 2024 revealed an order for Ativan give 0.5 mg tablet every 12 hours as needed for anxiety as evidenced by restlessness. This order had a discontinued date of September 10, 2024. The care plan initiated on September 5, 2024 (approximately 7 days after admission) revealed the resident used a psychotropic medication related to anxiety as evidenced by restlessness. The goal was that the resident will show decreased episodes of signs/symptoms of anxiety. Interventions included to administer medications as ordered, to monitor/document for side effects and effectiveness, and to offer non-pharmaceutical intervention prior to PRN (as needed) medication administration. The daily skilled nursing notes from September 1 through September 09, 2024 revealed the resident was oriented to person, place, time and situation; and, had no changes in cognitive function, no behavioral symptoms, no sign of distress and no evidence of signs or symptoms of restlessness or anxiety. Further review of the clinical record revealed no evidence found of any documentation of behaviors of anxiety and restlessness from September 1 through 9, 2024. The order for Ativan was transcribed onto the medication administration record (MAR) for September 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the MAR and treatment administration record (TAR) for September 2024 revealed that the presence of behavioral expression of anxiety as evidenced by restlessness was documented as not present for all shifts from September 1 through 9, 2024. Despite the lack of documentation, the MAR revealed that PRN Ativan was documented as administered on September 3, 4, 5, 6 and 7, 2024. In an interview with a registered nurse (RN/ staff #101) conducted on September 13, 2024 at 10:36 a.m., the RN stated that when giving PRN psychotropic medication, the nurses would monitor for and document the presence or absence of target behavior such as anxiety or restlessness. The RN said that the electronic medical record system triggers the necessary documentation on the MAR/TAR, that automatically pops up when the nurses go to administer the drug; and, a nurse could also document in the nursing progress notes to describe a resident's behaviors. During the interview, a review of the clinical record was conducted with the RN who stated that the target behavior as not observed for the dates in September when Ativan was administered. An interview was conducted on September 13, 2024 at 11:09 a.m. with the Director of Nursing (DON/staff #66) who stated that unnecessary medications should not be given; and that, there should be monitoring in place before and after administering a psychotropic medication to ensure that the medication was necessary and effective. A review of the clinical record was conducted by the DON who stated that behavior monitoring for anxiety and restlessness, that behavior was marked as not present in the MAR/TAR for resident #1 from September 1 through 9, 2024. The DON stated that administering Ativan when no behaviors of anxiety or restlessness were documented does not meet the facility's expectation. -Resident #23 was admitted on [DATE], with diagnoses that included Parkinson's Disease without dyskinesia without mention of fluctuations, and dementia. A review of the admission MDS assessment dated [DATE] revealed a BIMS score of 0 indicating the resident had severe cognitive impairment. The MDS also included that the resident no hallucinations, no delusions, and no other behavioral symptoms; was dependent for toileting, dressing, and bed mobility. The care plan dated August 23, 2024 revealed the resident used antipsychotic medications. Interventions included to administer medications as ordered, monitor/document side effects and effectiveness, monitor/record occurrence of target behaviors symptoms and document per facility protocol, and offer non-pharmacological intervention prior to PRN (as needed) medication administration. The physician order revealed an order dated August 28, 2024 revealed for Ativan to give 0.5 mg every 6 hours as needed for anxiety as evidenced by restlessness for 14 days. This order had a discontinue date of August 30, 2024. The psychotropic medication informed consent form signed August 28, 2024 revealed the resident was prescribed with an antianxiety medication, Ativan. The form included possible side effects and special concerns related to the use of Ativan. However, it did not include the target behavior for the use of Ativan and any non-pharmacological interventions recommended. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated August 30, 2024 included for Ativan to give one 1 mg tablet every 6 hours as needed for anxiety as evidenced by restlessness. This order had a discontinued date of September 9, 2024. The daily skilled note dated August 31, 2024 revealed that there were no changes in cognitive function, no behavioral symptoms and no concerns were noted during this shift. The order for Ativan was transcribed onto the MAR for August 2024 and revealed that Ativan was administered to the resident on August 30 and 31, 2024. However, there was no evidence found in the clinical record that the resident had exhibited the target behavior of restlessness on August 31, 2024. A nurse practitioner (NP) progress note dated September 1, 2024 included that on August 31, 2024, the resident was resting in bed and there were no further issues with agitation per nursing. It also included that on September 1, 2024, the resident was resting in bed and had no acute events overnight and no concerns per nursing. A daily skilled note dated September 1, 3 and 4, 2024 revealed no behavioral symptoms observed this shift; and that, the resident patient did better today and had less agitation. The NP progress note dated September 4, 2024 revealed that the resident was lying in bed asleep, difficult to arouse with verbal stimuli. Per the documentation, nursing reported no recent behavioral issues or concerns, has been calmer and more cooperative, and no reports of any further attempts to pull out his suprapubic catheter. Review of the care plan dated September 5, 2024 included that the resident used psychotropic medications related to anxiety disorder as evidenced by restlessness. Interventions included to give psychotropic medications as ordered and to monitor/document side effects and effectiveness. The NP progress note dated September 5, 2024 revealed the resident was seen sitting up in wheelchair at bedside, easily aroused by verbal stimuli, but was lethargic. Per the documentation, the resident had been calm and cooperative since his one previous episode of aggressive behavior. The daily skilled note on September 5, 2023 revealed no behavioral symptoms observed, no neuromuscular concerns reported or observed this shift. The physical therapy treatment encounter note dated September 5, 2024 revealed that the resident was lethargic throughout session and required cues to keep eyes open during the session. The daily skilled note on September 7, 2024 revealed no behavioral symptoms were observed this shift. The daily skilled note dated September 9, 2024 included the resident had no behavior or symptoms of restlessness. The physician order dated September 9, 2024 included the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ativan give 1 mg tablet every 6 hours as needed for anxiety as evidenced by restlessness until September 13, 2024; and, -Monitor for presence of behavioral expressions as evidenced by restlessness at the time of evaluation for Ativan use, every day and night shift. These orders were transcribed onto the MAR for September 2024. The psychotropic medication monitoring for September 2024 revealed that the presence or absence of behavioral expressions as evidenced by hallucinations and/or restlessness at the time of evaluation was documented as N indicating no behaviors noted from September 1 through 9, 2024. Despite documentation that resident did not have documented behavioral symptoms, review of the MAR for September 2024 revealed that Ativan was administered to the resident from September 1 through 9, 2024. There was no evidence found that non-pharmacological interventions for behaviors were provided or offered to the resident. An observation was conducted on September 09, 2024 at 11:05 a.m. The resident was lying in bed with no sheets or blankets on, had difficulty keeping his eyes open and was unable to answer questions for interview. In an interview conducted on September 10, 2024 at 11:31 a.m. a licensed practicing nurse (LPN/staff #74) stated that resident #23 had been compliant with care, had not demonstrated any behaviors, and was not given any Ativan this morning. The LPN stated that there was no documentation of any behaviors last night; and, the resident got a dose of Ativan last night. The LPN stated that she was not aware and was not familiar with any non-pharmacological interventions for behaviors in the resident's care plan. An interview with another LPN (staff #120) was conducted on September 11, 2024 at 12:15 p.m. The LPN stated that she was familiar with resident #23 since last week. The LPN said she had never had behaviors; but that, she had given the resident Ativan. In an interview with the charge nurse (staff #14) conducted on September 11, 2024 at 1:30 p.m., the charge nurse stated that a resident who started showing new behaviors would be referred to the psychiatric nurse practitioner. The charge nurse said that the new behaviors would be in the care plan, orders would be updated with the provider's recommendations and nursing report sheets would be updated. Further, the charge nurse stated that on the nursing report sheets. Staff #14 stated that they worked with Activities for non-pharmacological management; and this, should be passed on in report. An interview was conducted on September 11, 2024 at 1:38 p.m. with Life Enrichment Director (Activities/staff #4) who stated that if a resident was noted to have behaviors, she would try to come up with activities and interventions that help to manage a resident's behaviors. Regarding resident #23, the life enrichment director stated that she was just doing general activities with the resident; and that, she was not doing any specific interventions for any behavior for resident #23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with a nurse practitioner (NP/Staff #18) was conducted on September 12, 2024 at 9:36 a.m. The NP stated that behaviors for resident #23 included pulling out his suprapubic catheter, climbing out of bed, and hitting at staff. The NP stated that after the resident pulled out his catheter the second time, they got psych involved and the psych provider got some Ativan for the resident. In an interview on September 12, 2024 at 9:42 a.m., the psychiatric nurse practitioner (NP/staff #40) stated that she had known resident #23 to have behaviors such as pulling out his suprapubic catheter, trying to get out of bed on his own, was a high fall risk, was impulsive; and, staff reported resident became aggressive. Staff #40 stated that she increased the resident's dosage for his antipsychotic medications and added the PRN Ativan as an intervention. Staff #40 said that if staff notices the resident was restless and other interventions were not working, then the PRN Ativan would be indicated. Further, staff #40 said that her expectation was that staff would not administer PRN Ativan if the resident was not displaying any behaviors because that would not be the intention of what that medication was for; and that, the risks of this over time could be increased sedation and lethargy, and, as the medication wore off there could be increased confusion. During an interview with the Director of Nursing (DON) conducted on September 12, 2024 at 1:57 p.m., the DON stated that if a resident started to demonstrate adverse behaviors, staff would notify the provider, obtain orders, and revise the care plan based on the needs of the individual. Regarding resident #23, the DON stated that the resident had tremors that were jolting him out of bed; and that, it would appear that he was striking out, but it was not a behavior, and the resident had no other behaviors. The DON further stated that for a PRN psychotropic medication, monitoring of resident behavior was needed before the dose is given to ensure the PRN medication was truly needed; and, staff would follow and proceed with what interventions were in the care plan. Further, the DON stated that based on the clinical records, there was no non-pharmacological interventions that were documented as offered to resident #23 prior to the administration of PRN medications. The DON said that if a nurse noticed no symptoms or behaviors but still gave PRN Ativan, it would not meet the facility's expectation, and the risk of this would be a resident experiencing potential side effects from the drug. A review of the facility's policy titled Behavioral Assessment, Intervention, and Monitoring, revised December 2016, revealed that if antipsychotic medications are used to treat behavioral symptoms, the IDT will monitor their indication. Additionally, the IDT will monitor for side effects of psychoactive medications; for example, lethargy and abnormal involuntary movements. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. The care plan will include, as a minimum: A description of the behavioral symptoms, including: (1) Frequency; (2) Intensity; (3) Duration; (4) Outcomes; (5) Location; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(6) Environment; and (7) Precipitating factors or situations A review of the facility's policy titled Psychotropic Medication Use, revised November, 2016 revealed that psychotropic medications may be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use. The facility staff should monitor the resident's behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of the symptoms, and the resident's response to staff interventions. The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social, or environmental cause of the resident's behaviors.

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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. 50862 Based on observation, staff interview, and policy review, the facility failed to ensure treatment cart was not left unlocked and unsupervised; and, failed to ensure there were no expired medications readily available for resident use in the treatment cart. The deficient practice could result in the potential for unauthorized non-medical trained individuals to have access to treatment medications with risk of misusage and related risk of allergic reactions. Findings include: An observation of the treatment cart on the second floor was conducted on September 13, 2024 at 8:19 a.m. The nurse entered a resident room and left the treatment cart unlocked and unsupervised. An interview with a licensed practical nurse (LPN/staff #120) was conducted on September 13, 2024 8:35 a.m. The LPN stated that medication carts were to be locked at all times when unsupervised; and, after the treatment has been done/completed, the treatment cart was to be locked. An observation of the treatment cart that was left unlocked was conducted with the LPN who stated that she does not know the risk of treatment cart being unlocked; and that, there was no medications in the treatment cart. During the interview, the second drawer on treatment cart was slid open and revealed the following medications: hydrocortisone (corticosteroid), silvasorb gel silver (topical anti-infective)antimicrobial wound gel, diclofenac sodium (topical analgesic) 1% gel, triamcinolone (corticosteroid), clobetasol (corticosteroid) emollient, lidocaine (topical anesthesia) 5%. The LPN then proceeded to lock the treatment cart. An observation of the treatment cart on the first floor was conducted with another LPN (staff #138) on September 13, 2024 at 8:48 a.m. and revealed the following treatment medications that were expired: -Collagenase Santyl (topical debriding agent) with expiration date of July 2024; -Silvasorb gel silver antimicrobial wound gel with expiration date of February 2024; and, -Binax COVID test kit. An interview with the LPN (staff #138) was conducted immediately following the observation. The LPN stated that an unlocked treatment cart has the risk of treatment medications getting into the resident's hands; and that, she would not want a resident to get into the medications. The LPN removed the expired treatment medication from the treatment cart and stated that all expired medications are taken to the office of the Director of Nursing (DON). In an interview with the DON conducted on September 13, 2024 at 10:25 a.m., the DON stated that an unlocked and unsupervised medication or treatment cart left had a risk of residents having access to medications that they do not need. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Administering Medications revealed that during administration of medications, the cart will be kept closed and locked when out of sight of the medication-nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. The policy revealed the procedure that the expiration/beyond use date on the medication label must be checked prior to administering and when opening a multi-dose container, the date opened shall be recorded on the container. Review of facility's policy on Storage of Medications, included that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals, and that compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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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** 51124 Based on observation, record review, interviews, and facility policy review, the facility failed to follow infection control standards on enhanced barrier precautions (EBP) for 3 of 3 sampled residents (#23, #26, and #24). The deficient practice could lead to spread of infections. Findings include: -Resident #23 was admitted on [DATE], with diagnoses of urinary tract infection, neuromuscular dysfunction of bladder, retention of urine, Parkinson's Disease without dyskinesia without mention of fluctuations, and dementia. The care plan initiated August 19, 2024 revealed that the resident required enhanced barrier precautions (EBP) due to suprapubic catheter. Interventions included to ensure EBP were followed during high-contact interaction or procedures per facility i.e. dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, toileting, device care: urinary catheter. A review of the admission MDS assessment dated [DATE] revealed a BIMS score of 0 indicating the resident had severe cognitive impairment. The MDS also included that the resident was dependent for toileting, dressing, and bed mobility; and had an indwelling catheter and a urinary tract infection within the last 30 days. A physician order dated August 29, 2024 revealed and order for catheter care every shift. Review of the physician order dated September 9, 2024 included to maintain enhanced barrier precautions per facility policies and procedures for catheter. An observation of the room of resident #23 was conducted on September 9, 2024 at 11:04 a.m. and revealed no signs posted on the door or doorway that the resident was on EBP. The resident was in bed with a catheter bag hanging at the side of the bed. Another observation was conducted on September 9, 2024 at 3:05 p.m. A new sign for EBP was now posted on the doorway of resident's (#23) room. However, there was no storage bin or any receptacle for personal protective equipment (PPE) such as gowns located or found. At the time of the observation, there was a staff inside the resident's room and was working with the resident. The staff member had gloves on, but was not wearing a gown. The staff member assisted the resident to sit on the edge of the bed and then moved the resident's catheter bag from the far side of the bed to the same side of the bed in which the resident was sitting. At 3:14 p.m., a certified nursing assistant (CNA/staff#141) entered the room and proceeded to put gloves on; however, the CNA did not wear a gown. The two staff members in the room had close physical contact with the resident and assisted resident #23 with a bed-to-wheelchair transfer. An interview was conducted on September 09, 2024 at 11:05 a.m. with the resident's family who stated that staff provided regular and timely catheter care to resident #23. She stated that staff wear gloves but, never put on a gown while providing catheter care to resident #23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the certified nursing assistant (CNA/staff #141) conducted on September 9, 2024 at 3:19 p.m., the CNA stated that this was her first day at this facility; and that, the facility had not done any training with her regarding transmission-based precautions. The CNA said that if a resident was on precaution, the PPE was located outside of the room; and, there was no PPE located inside the resident's room. Regarding resident #23, the CNA stated that the resident was not on any precautions; and, she did not know what EBP meant and have never seen EBP. The CNA further stated that if infection control precautions were not maintained, the risk to residents would be the spread of infection. -Resident #26 was admitted on [DATE], with diagnoses of metabolic encephalopathy, acute respiratory failure, and Alzheimer's dementia. A physician order dated August 27, 2024 included for catheter care every shift. The physician order dated August 28, 2024 included to ensure EBP were followed during high contact resident interaction or procedures per facility i.e., dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, toileting, device care or use due to the presence of the resident's Foley catheter. The care plan initiated August 28, 2024 revealed that the resident required EBP due to Foley catheter. Interventions included to ensure EBP were followed during high-contact resident interaction or procedures per facility i.e. dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, toileting, device care: urinary catheter. The admission MDS assessment dated [DATE] revealed that resident had a BIMS score of 0 indicating the resident had severe cognitive impairment. The MDS also included that the resident was dependent for rolling in bed, required partial assistance for toileting and dressing, and, had an indwelling catheter. An observation of the room of resident #26 was conducted on September 9, 2024 at approximately 12:45 p. m. There were no signs posted that the resident was on EBP. A licensed practical nurse (LPN/staff #95) and another staff member entered the room to assist the resident who was visibly soiled and required a brief and linen change. Both staffs were wearing gloves when they changed the resident's bed linens. However, neither staff were wearing gown. In an interview with the licensed practical nurse (LPN/Staff #95) conducted on September 9, 2024, at 12:52 p. m., the LPN initially stated that resident #26 was not on any precautions. The LPN then retracted her statement and said that the resident had a Foley catheter so the resident should be on EBP. The LPN also stated that there was no sign on the door or the resident's (#23) room; and, there were no PPE such as gowns present inside or outside of the room. Further, the LPN said that there should be. An interview was conducted on September 11, 2024 at 12:39 PM with the Director of Nursing (DON) who was also the designated Infection Preventionist (IP). The DON/IP stated that if a resident was on EBP, the PPE was kept in the room and there should be a signage that goes on the door of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #24 was admitted on [DATE] with diagnoses of fracture of right tibia, heart failure, and severe protein-calorie malnutrition. The admission MDS assessment dated [DATE] revealed a BIMS score of 15 indicating the resident had intact cognition. The MDS also included that the resident required supervision or touching assistance for bed mobility, bed-to-chair transfers, toilet transfers, and walking 10 feet. The physician order dated August 28, 2024 revealed an order for wound care treatment to sacrum pressure injury. A physician order dated September 7, 2024 included for peripheral IV (intravenous) for IV therapy. The physician order dated September 9, 2024 included to maintain EBP per facility policy for peripheral IV therapy. Review of the care plan initiated September 9, 2024 revealed that the resident required EBP due to the presence of a wound. Interventions included to ensure EBP were followed during high-contact patient interaction or procedures per facility i.e. dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, toileting, device care: central line, or wound care of any skin opening requiring a dressing. An observation of the room of resident #24 was conducted on September 12, 2024 at 12:44 p.m. There were no signs posted on or near the door that the resident was on EBP. There was also no storage bins or PPE such as gowns located on the door or outside the resident's room. Another observation conducted on September 13, 2024 at 9:00 a.m. revealed that there was still no EBP signs posted; and, no bins for PPE was present outside the room. A contract phlebotomist entered the resident's room and put on gloves. The phlebotomist did not put on a gown. The phlebotomist then proceeded to draw the resident's blood. An interview with the wound nurse (staff #111) was conducted on September 13, 2024 at 9:20 a.m. The wound nurse stated that PPE should be available for direct care staff and a sign regarding precautions should be posted on the door frame. Further, the wound nurse stated that PPE and supplies for dressing changes were stored in the mobile wound care cart. In an interview with the DON conducted on September 13, 2024 at approximately 11:35 a.m., the DON stated that EBP was part of the care plan; and that, it was expected that EBP were followed per facility protocol. In a later interview with the DON conducted on September 13, 2024 at approximately 12:45 p.m., the DON stated that resident rooms that were on precautions such as EBP were supposed to be identified properly with signs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy on Enhanced Barrier Precautions revised in August 2022 revealed that EBP are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities. Gloves and gown are applied prior to performing high contact resident care activities which include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheter, feeding tube, etc.), and wound care (any skin opening requiring a dressing). Further, staff are trained prior to caring for residents on EBPs. The policy also included that signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is to be available outside of the resident rooms. 51103 -Resident #24 was admitted on [DATE] with diagnoses of closed right tibia fracture with routine healing, anemia, opioid dependence, pressure induced deep tissue damage of sacral region, and pressure injury of the right upper back. The hospital discharge report dated August 16, 2024 revealed the resident had pressure induced deep tissue damage of sacral region, and a pressure injury of the right upper back. The skin integrity care plan dated August 16, 2024 included that the resident had the potential or was at risk for skin impairment related to advanced age,Braden score and impaired mobility. Interventions included to administer treatment to wound/skin impairment per physician orders. The skin evaluation summary dated August 16, 2024 revealed the resident's skin was warm and dry, had good skin turgor; and, resident had splint, brace and immobilizer present. The skin evaluations dated August 28, September 4, and 11, 2024 revealed the resident /24, 09/04/24, and 9/11/24 reveal size, staging, and percentage improvement of resident's #24 skin impairments. Measurable goals for these skin impairments descriptions are not identified in the care plan. Review of clinical physician order dated 9/9/24 instructs direct care staff to provide wound care to the sacrum and right upper back by cleansing wound with wound cleanser, pat dry, apply Medihoney, and to cover with a dry dressing during the night shift on Monday's, Wednesday's, and Friday's. These ordered interventions are not included in the skin impairment care plan. Regarding facility staff failed to implement care plan EBP intervention; Review of the order summary and resident care plan for Enhanced Barrier Precautions (EBP) were initiated on 9/9/24. The facility was to ensure EBP are followed per facility protocol. During a facility observation of resident #24 room, spanning from August 9, 2024 at 8:40 am - August 13, 2024 at 9:45 am; no Enhanced Barrier Precautions (EBP) signage was present on door or wall. In addition, no personal protection equipment station was in close proximity to resident #24 room. During an observation on 9/13/24 at 9:09 a.m. observed resident laying very still in bed, wearing dark sunshades while a third-party phlebotomist performed venipuncture of resident's left arm. Phlebotomist is wearing gloves and a surgical mask during procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with third party phlebotomist conducted 9/13/24 at 9:13 a.m. phlebotomist stated unawareness of resident being on contact precautions because there was no sign on door, or a PPE cart close by. Interview with WCN/Staff #111 on 9/13/24 at 9:20 am, WCN acknowledged PPE was to be available for direct care staff and a sign stating as such posted on door frame. WCN stated personal complete compliance with PPE as the wound care provider for the facility. WCN stated that personal PPE and supplies for dressing changes are stored in the mobile wound care cart. In an interview with Director of Nursing/Staff # 66 conducted on 9/13/24 at approximately 11:35 am, DON identified EBP was part of the care plan, thus facility protocol for EBP was expected to be followed. According to facility policy entitled Enhanced Barrier Precautions, Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms.