STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115206	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Center for Nursing and Healing	811 Kennesaw Avenue Marietta, GA 30060

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49681 Based on observations, record review, and review of the facility policy titled, Activities of Daily Living (ADL), the facility failed to give a dependent resident the appropriate assistance with eating meals and to ensure meals in their room in a timely manner for one of 41 sampled residents (R) (R25). The deficient practice had the potiential to cause weight loss for R25. Findings include: Review of the undated facility policy titled Activities of Daily Living revealed under Policy: Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrates that such diminution was unavoidable. Activities of daily living (ADLs) include: Hygiene-bathing, dressing, grooming, and oral care; Mobility-transfer and ambulation, including walking; Elimination-toileting; Dining-eating, including meals and snacks; Communication-including speech, language, and other functional communication systems. Practice Standards: 1.2. A patient who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the electronic medical record (EMR) for R25 revealed diagnoses including but not limited to Todd's paralysis (postictal paralysis), aphasia, need for assistance with personal care, other lack of coordination, muscle weakness (generalized), need for assistance with personal care, other lack of coordination. (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	Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] for R25 revealed a Brief Interview for Mental Status (BIMS) score of 99, which indicates R25 was not able complete the interview-resident is rarely or never understood. Section GG (Functional Abilities and Goals) indicated full dependence on staff with ADL's, including eating. Review of the care plan for R25 revealed interventions to monitor, document, and report PRN (as needed) any of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. The resident has potential nutritional problem r/t [related to] texture modified diet, use PEG [percutaneous endoscopic gastrostomy] tube. R25 has an ADL self-care performance deficit r/t activity intolerance, disease process 2/28/2023. Observation on 2/14/2024 at 9:35 am of R25 being feed by a Certified Nurse Assistant (CNA). Breakfast consists of eggs, grits, and milk. Resident was eating very good with assistance. Observation on 2/15/24 at 9:37 am of R25 with a breakfast tray to the left side of her bed. It appeared that she was set up prepared to eat. Food was all over her clothes, face, and hands. It appeared as though she was trying to feed herself. I observed resident (R) R25 silverware was still in the napkin wrapped up and the milk was unopened.

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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** 36377 45813 Based on observations, resident and staff interviews, record review, and review of the facility policies titled, Resident Self-Administration of Medications and Medication Administration, the facility failed to ensure five of 41 sampled residents (R) (R22, R39, R90, R81, and R1) reviewed for self-administration of medications did not have medications stored at the bedside. This deficient practice had the potential to allow residents to administer the medications in an unsafe manner. Findings include: A review of the facility's undated policy titled Resident Self-Administration of Medication, revealed the Policy Statement: A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. 4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. 7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. 8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage, Unauthorized medications are given to the charge nurse for return to the family or responsible party. 13. The care plan must reflect resident self-administration and storage arrangements for such medications. A review of the facility's undated policy titled Medication Administration, revealed Policy: A licensed nurse, Med Tech, or medication aide, per state regulations will administer medications to patients. 8. Administer medications. 8.2: Remain with patient until administration is complete. Do not leave medications at the patient's bedside. 1. Review of R22's record revealed resident was admitted to the facility 1/29/2024 with diagnosis to include but not limited to diabetes mellitus, anxiety disorder, depression, and cerebral infarction. A review of the Admission Minimum Data Set (MDS) dated [DATE] revealed in section C - Cognitive Patterns: Brief interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. Observations on 2/13/2024 at 10:27 am, and at 12:50 pm revealed multiple medications at R22's bedside on the dresser to include a bottle of 8-Hour Arthritis Pain Relief 650 mg (milligram) tablets, a tube of zinc oxide ointment, a box of Hydroxcut weight loss electrolytes drink mix, a tube of Triple Action Relief Foot Cream, a bottle of loperamide hydrochloride (anti-diarrheal) oral solution, a box of effervescent antacid, and a bottle of nasal spray. R22 informed the surveyor his wife brought the medications to him, and he uses the medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R22's electronic medical record (EMR) under the Order tab revealed that R22 did not have a current order for the medications at the bedside. Review of R22's care plan revealed there was nothing implemented in the plan of care allowing resident to self-administer or store medications at the bedside, Further review of the EMR revealed that R22 did not have an assessment to self-administer medications or keep medications at the bedside. Interview and walking rounds on 2/13/2024 at 12:53 pm with LPN Unit Manager AA revealed that R22 should not have any medications at the bedside. LPN AA verified all medications at the bedside, and with R22's permission, removed the medications. LPN AA verified R22 did not have current orders, self-administration assessment, or care plan for the medications retrieved from his room. Interview on 2/13/2024 at 1:10 pm with RN DD revealed upon arrival to work, she peeked in on R22. RN DD further stated, she later went into R22's room to administer his am medications but did not notice the medications on his bedside table. RN DD stated that she was aware residents are not supposed to have medications in the room but are required to be locked up. Review of the EMR revealed R39 was admitted to the facility with diagnosis to include but not limited to diabetes mellitus, depression disorder, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed in Section C - Cognitive Patterns: Brief interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Section GG - Functional Abilities and Goals revealed R39 had an impairment on one side of his upper extremity. Observations on 2/13/2024 at 9:44 am and at 12:24 pm revealed a bottle of fluticasone propionate nasal spray and two Stiolto Respimat Aerosol (breathing medication) on R39's bedside table within resident's reach. Review of R39's EMR under the Order tab revealed R39 did have orders for fluticasone propionate nasal suspension 50 MCG/ACT [micrograms per actuation] (Fluticasone Propionate (Nasal Spray) 1 spray in each nostril one time a day for nasal congestion and Stiolto Respimat 2.5-2.5 MCG/ACT Aerosol, solution 2 puff inhale orally one time a day for COPD [chronic obstructive pulmonary disease]. However, the order did not indicate whether R39 may self- administer medications or if medications could be stored at R39's bedside. Review of R39's care plan revealed there was nothing implemented in the plan of care allowing resident to self-administer or store medications at the bedside, Further review of R39's EMR revealed a Medication Self-Administration Screen dated 5/29/2023 which indicated R39 was allowed to self-administer albuterol sulfate inhalation nebulization solution (2.5mg/3 ml (milliliter) 0.083%. Staff will continue to store and administer medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 2/13/2024 at 9:50 am with R39 revealed he had always been allowed to keep his inhalers and nasal spray at the bedside to administer himself as he needed it. R39 stated the staff was aware that he had the medications, and the nurse reorders the medications and brings it to his room when the pharmacy delivers it to the facility. Interview and walking rounds on 2/13/2024 at 12:57 pm with LPN Unit Manager AA revealed R39 should not have any medications at the bedside. LPN AA verified all medications at the bedside and with R39's permission, removed the medications. LPN looked at the current orders and verified R39 did have orders for the medications, but not to be kept at bedside for self-administration. LPN AA also verified R39's care plan did not allow the resident to keep medications at the bedside. LPN AA also verified R39 had a self-administration assessment in the record to self-medicate nebulizer solution only, not inhalers or nasal spray. Interview on 2/13/2024 at 1:22 pm with LPN BB revealed she was aware R39 had the inhalers and nasal spray on his bedside table. LPN BB further stated she had informed the administrative staff, and they did not put an order in for R39 to keep the medications at bedside, nor did they remove the medications from the room. LPN BB further stated R39 keeps the medications himself to administer because he refuses to allow the nurses to administer the inhaler and nasal spray. Review of R90's EMR revealed resident was admitted to the facility with diagnosis to include but not limited to diabetes mellitus, muscle weakness, need for assistance with personal care, and Guillain-Barre Syndrome. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed in Section C - Cognitive Patterns: Brief interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Observations on 2/13/2024 at 10:51 am upon entering R90's room, resident had a plastic cup of medications on the table in front of him. R90 stated the nurse gave him the medications and left. Resident further stated he had not taken the medications because the nurse did not give him the ibuprofen he requested. Further observations revealed RN DD down the hall administering medications, she confirmed she left the medications at R90's bedside and stated the resident told her she did not have to watch him take his medications. At 11:06 am RN DD was observed back in R90's room asking him to take the medications she had previously left with him. Interview on 2/13/2024 at 1:36 pm with the Director of Nursing (DON) revealed nurses are expected to stay with residents to ensure medications are swallowed prior to leaving the room. The DON further stated that residents should not have medications at their bedside if they have not been assessed and have an order and a care plan indicating they are safe to self-medicate. RN DD confessed to the DON that she had given R90 his medications and walked away prior to ensuring R90 had consumed the medications. The DON also stated residents are not allowed to have medications at the bedside to self-administer unless they have been assessed by the nurse and deemed safe to do so. The DON further stated in this case, there would be an assessment, an order, and a care plan indicating resident was safe to self-medicate. 2. Observation on 2/13/2024 at 11:21 am revealed the following medication within visual sight on the bedside nightstand and in an open cart in R1's room: A prescription bottle of amoxicillin (labeled with the res (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ident's name and identified information), an unidentified bottle of white pills with the prescription labeled removed, a bottle of over the counter (OTC) eye drops, a bottle of pure moist [NAME] hydraclyde eye drops, three bottles of allergy eye drops, a bottle of Tylenol pills, a bottle of nose spray, and a container of calcium tablets. At the time of observation on 2/13/2024 at 11:21 am, R1 revealed that she received the antibiotic (Amoxicillin) and the unlabeled prescription bottle of pills that she identified as Tylenol/pain medication from her dentist. R1 reported that a family member provided transportation to the dentist last month. She reported having extractions of her bottom teeth. She reported not telling the facility staff about the medications. She stated that all the OTC meds were from her daughter. R1 reported taking the medication without staff supervision. Review of R1 's EMR revealed the following diagnoses but not limited to cardiac pacemaker, congestive heart failure, chronic pulmonary heart disease, and respiratory failure with hypoxia. Review of R1's quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating intact cognition. R1 was assessed for partial assistance to supervision assistance with the majority of her Activities of Daily Living (ADL). Review of R1's January 2024 physician orders revealed no physician order for self-administration of medications. Continued review of the physician orders revealed the following active medications but not limited to oxycodone HCl (hydrochloride) 30 mg, take every six hours for pain (start date 7/28/2023), Narcan nasal liquid 4mg/4ml (milliliter) one application every twenty four hours as needed for opiate overdose, Xtampza ER oral capsule ER 12 hours abuse deterrent 18 mg (oxycodone) give one capsule by mouth two times a day for pain, levalbuterol tartrate inhalation aerosol 45 mcg two puffs, cetirizine HCl oral tablet 10 mg give one tablet by mouth one time a day for seasonal allergies, and digoxin 125 mcg daily. A later review of the physician order revealed that a new order for amoxicillin 500 mg (three times a day) was added on 2/13/2024 due to staff removing the resident's personal prescription bottle of amoxicillin from her room. Review of R1's assessment's records revealed that no self-administration assessment evaluation was initiated by the facility staff to indicate the resident competency level to self-administer medications. Review of the care plans in R1's clinical record revealed an omission of a plan of care to self-administrate medications. Interview on 2/13/2024 at 11:45 am with the Administrator, Licensed Practical Nurse (LPN) HH, and Unit Manager LPN JJ, conducted at the time of the observation of R1's bedside medications revealed that all the medications were confirmed and verified by all the mentioned staff. Unit Manager JJ reported that the unidentified medication in the unlabeled prescription bottle could not be determined. LPN HH and Unit Manager LPN JJ reported being unaware of medications at the bedside. LPN HH confirmed that R1 was not approved for self-administration of medications. LPN HH stated that R1 was not capable of taking her medications without supervision. The Administrator reported her expectation was that staff should have been aware of residents having unauthorized medications in their room. Interview on 2/15/2024 at 11:22 am with the Social Worker revealed having no record of R1's dental visit. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/13/2024 at 11:24 am revealed R81 lying in bed and a small bottle of eye drops dry eye relief 1 FL OZ /30 ml (one fluid ounce/30 milliliter) sitting on the bedside within visual sight. Review of R81's EMR revealed the following diagnoses but not limited to chronic atrial fibrillation, acute kidney failure, and pleural effusion not yet classified. The quarterly MDS dated [DATE] assessed a BIMS score of 13, which indicates cognition intact with no cognitive impairments. R81 was assessed for partial to substantial assistance with upper body Activities of Daily Living Skills. Range of Motion (ROM) assessed for no impairment for upper/lower body. Review of R81's February 2024 physician orders documented the following medications but not limited to Norco oral tablet 10-325 mg (hydrocodone-acetaminophen)-give 1 tablet by mouth four times a day for pain, acetaminophen oral tablet 500 mg give two tablet by mouth every six hours as needed for pain, Eliquis (blood thinner) 5 mg give 1 tablet by mouth two times a day, tamsulosin HCl (for urine flow issues) 0.4 mg give 1 capsule by mouth one time a day. Review of R81's physician orders revealed no order for self-administration of medications. Review of R81 care plans revealed no plan of care to self-administer medications. R81 had a Self-Administration Medication Assessment evaluation form in his record dated 9/28/2023 that stated, refresh eye drops/bedside with resident and resident to self-administrate medications with supervision. An interview and observation on 2/13/2024 at 11:15 am of the observation of R81's bedside medications with the Administrator, Licensed Practical Nurse (LPN) HH, and Unit Manager LPN JJ. The medications were confirmed and verified by the above-mentioned staff. LPN HH and Unit Manager LPN JJ reported being unaware of medication (eye drop) at the bedside. LPN HH confirmed that R81 was not approved for self-administration of medications. She only had one resident on A Hall who was approved to self-administer medication. Unit Manager LPN JJ removed the medication (eye drop) from the room. The Administrator reported her expectation as that staff should have been aware of residents having unauthorized medications in their room. Interview on 2/13/2024 at 11:24 am with the Administrator, Licensed Practical Nurse (LPN) HH, and Unit Manager LPN JJ, R81 stated to Unit Manager LPN JJ he was using the eye drops every 12 hours and that the nurse (unidentified nurse) gave it to him. He reported that he did not have anyone watching him (supervising him taking the eyedrops). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 2/15/2024 at 11:10 am with the DON, he reported that his expectation was that staff should conduct routine room audit checks. He identified the problem area as a system failure due to long-term residents having the right to order their own stuff online. This makes it hard for nursing staff to track and check residents' personal packages. When inquired if certified nursing assistant staff have a role in monitoring for unauthorized medication and products, he stated that all staff are educated on room monitoring. However, Certified Nursing Assistants (CNAs) are trained on safety and not trained to know medications and bottles. He stated that the CNAs would receive extra hands-on training. The DON stated that R1 received antibiotic medication from the dentist. He had no comment on the unidentified, unlabeled pain medication. He explained the facility's process for self-administration of medications approval depends on an assessment and a discussion of the resident by the Interdisciplinary Team (IDT). The IDT team would meet to discuss the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observations, resident and staff interviews, record review, and review of the facility policies titled, Wound Treatment Management and Charting and Documentation, the facility failed to provided treatment and care in accordance with professional standards for two of 41 sampled residents (R) (R42 and R81) related to failure to document wound care was performed as ordered by the physician. The deficient practice had the potential to cause further decline and possible infection of wounds. Findings included: Review of the facility policy titled Wound Treatment Management dated August 2023 revealed under Policy Statement: To promote wound healing of various types of wounds, it is the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing changes. 6. c. The facility will follow specific physician orders for providing wound care. 7. Treatments will be documented on the Treatment Administration Record (TAR) or in the electronic health record. Review of the facility policy titled Charting and Documentation revised July 2017 revealed in the Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medial record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Under the section Policy Interpretation and Implementation: 2. The following information is to be documented in the resident's medical record, C - treatments or services performed. 7. Documentation of procedures and treatments will include: a. care-specific details, including: a. the date and time the procedure/treatment was provided, b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician, or other staff, if indicated, and; g. the signature and title of the individual documenting. 1. Review of the Electronic Medical Record (EMR) revealed that R42 had a diagnosis of but not limited to non-pressure chronic ulcer of left thigh, rosacea, lack of coordination, morbid (severe) obesity due to excess calories, local infection of the skin and subcutaneous tissue, punctate keratitis, bilateral, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed in Section C - Cognitive Patterns: Brief interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Section M - Skin Condition revealed R42 had a surgical wound. R42 had a care plan related to surgical wound with an initial date of 8/24/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current physician orders in the EMR revealed R42 had an order for the Left inner Thigh: Cleanse wound with wound cleanser. Pat dry. Apply Calcium Ag. [alginate] Cover with ABD [abdominal] Pad. Change daily and as needed (PRN) two times a day. Start date 12/28/2023. Review of the Treatment Administration Record (TAR) for December 2023 revealed daily treatment to R42's left inner thigh was not documented as completed on 12/3/2023, 12/6/2023, 12/9/2023, 12/10/2023, 12/13/2023 through 12/17/2023, and 12/21/2023 through 12/28/2023. The order changed to twice daily on 12/28/2023. The treatment to the surgical wound was not documented as completed on 12/29/2023 and 12/31/2023 at 9:00 am and 9:00 pm. In addition, the treatment was not documented as completed on 12/30/2023 at 9:00 pm. Review of the TAR for January 2024 revealed the twice daily treatment to R42's inner thigh was not documented as completed on 1/1/2024, 1/4/2024, 1/5/2024, 1/7/2024, 1/8/2024, 1/14/2024 through 1/17/2024, 1/21/2024, 1/22/2024, 1/27/2024 through 1/29/2024, 1/2/2024, 1/6/2024, 1/18/2024 through 1/20/2024, 1/23/2024, and 1/26/2024 at 9:00 am, and 1/3/2024 at 9:00 pm. Review of the TAR for February 2024 revealed the twice daily treatment to R42's inner thigh was not documented as completed on 2/1/2024 through 2/4/2024, 2/7/2024, 2/13/2024, 2/11/2024 at 9:00 am, and 2/4/2024, 2/10/2024, 2/11/2024 and 2/14/2024 at 9:00 pm. Wound observation 2/14/2024 at 9:27 am revealed R42's wound observation with LPN wound nurse GG. Wound Nurse GG explained the procedure to R42. Supplies were gathered, provided privacy, resident repositioned, and was assessed for pain. Hand hygiene was performed, the wound was assessed, the wound was cleansed, and application of medications and dressings as ordered by the physician was performed. R42 was assessed for pain and repositioned. R42 tolerated the procedure well and was appreciative of the dressing change. Hand hygiene was performed within standard practice throughout the procedure. Interview on 2/13/2024 at 10:52 am with R42 revealed the facility had finally hired a wound nurse to do his dressing changes. R42 further stated the previous wound nurse left a couple of months ago, so the care of his wound was not being treated consistently. He stated that the wound care was sometimes done by the hall nurses and at other times he had to care for his own wound, despite it being on his backside. Interview on 2/14/2024 at 9:19 am with the Wound Nurse Practitioner revealed R42's wound was a chronic wound that he has had for 4 years. She further stated that R42 cannot reposition himself, so the goal for him was to reduce the risks of the wound getting infected. Interview on 2/14/2024 at 9:21 am with LPN Wound Nurse GG revealed she just started as the wound nurse approximately 2 weeks ago. LPN GG stated prior to her being promoted to the wound nurse position, the facility did not have a wound nurse, so the nurses assigned to the residents with wounds were responsible to do wound care. LPN GG further stated nurses are required to document the wound care was complete in the EMR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/14/2024 at 3:54 pm with the Director of Nursing (DON) revealed the last wound nurse did leave in November 2023. The DON further stated at that time the former DON was overseeing the wound program and the nurses assigned to the residents with wounds were responsible for ensuring residents wound care was done. The DON further stated that the new wound nurse started the position about 2 weeks ago. The DON stated that when the wound treatments are performed it should be documented in the EMR on the TAR. The DON stated during that time the facility utilized a lot of agency nurses, so accountability was hard. During a follow-up interview on 2/15/2024 at 9:18 am with the DON, he verified the treatments for R42 and R81 were not documented as completed as ordered by the physician. The DON also stated the wound nurse was responsible for treatment on Mondays, Wednesdays, and Fridays and the hall nurses are responsible for treatment on all other days. The DON further stated the nursing administration staff are new to their perspective roles so the audits for compliance are not being done yet. 47146 2. Observation of wound care for R81's sacral wound with LPN Wound Care Nurse GG and the Wound Care Nurse Practitioner (NP) revealed LPN Wound Nurse GG consulted the wound care orders, assessed the resident's pain, assembled supplies, cleaned the overbed table with facility approved disinfectant, allowed proper wet time, then she utilized a barrier for the table which she placed her supplies for the wound treatment. She performed hand hygiene utilizing soap and water before starting and throughout the treatment at each glove change and upon exiting the room. She assisted R81 onto his right side. She removed the old dressing, discarded all soiled dressings into a biohazard bag, doffed (took off) gloves, performed hand hygiene, then donned (put on) clean gloves. The Wound Care NP, after performing hand hygiene with hand sanitizer, donned clean gloves and measured the wound, after which she doffed her gloves, performed hand hygiene with hand sanitizer, then donned clean gloves and assisted LPN Wound Nurse GG with positioning of the resident. LPN Wound Nurse GG cleansed the wound as directed in the physician orders, doffed gloves, performed hand hygiene, then donned clean gloves. She then provided the wound treatment as directed in the physician orders, covered the wound with a dressing and labeled the dressing with the date and her initials. She doffed her gloves, performed hand hygiene, and donned clean gloves. She gathered the biohazard bag and discarded all dressing wrappings and the barrier from the table. She cleaned the table again with facility approved disinfectant, then removed the biohazard trash from the room. She reassessed the residents pain level before leaving the resident. Review of R81's physician orders included but not limited to sacrum pressure stage IV (four) cleanse with 1/4 strength Dakin's solution (wound cleanser), pat dry, apply no sting skin prep to peri (around)-wound, apply calcium algenate -AG, cover with bordered gauze, every day. Start date 12/13/2023. Review of R81's care plan revealed a focus of R81 has a pressure ulcer stage four (4) to sacrum related to history of ulcers, bowel incontinence, and immobility (date initiated 9/13/2023, created by MDS coordinator, Revision on 12/13/2023 by reimbursement specialist). Goal was R81's pressure ulcer will show signs of healing and remain free from infection by/through review date (date initiated 9/13/2023 by MDS coordinator; revision of 9/28/2023 by reimbursement specialist). Interventions included but not limited to administer treatments as ordered and monitor for effectiveness (date initiated/created 9/13/2023 by MDS Coordinator) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R81's TAR for the sacral wound in December 2023 revealed daily wound care orders were started on 12/13/2023. Review of the TAR revealed there were only three dressing changes documented for the sacral wound between 12/13/2023 through 12/31/2023, on 12/13/2023, 12/28/2023, and 12/30/2023. Review of R81's TAR for January 2024 revealed daily wound care to the sacral wound ordered and there were eight dressing changes documented for the entire month of January. Dressing changes were documented as completed only on 1/2/2024, 1/16/2024, 1/18/2024, 1/19/2024, 1/20/2024, 1/24/2024, 1/29/2024, and 1/30/2024. Review of R81's TAR for February 2024 revealed daily wound care to the sacral wound, and between 2/1/2024 and 2/14/2024 there were six dressing changes documented as completed. Dressing changes were documented as completed on 2/2/2024, 2/3/2024, 2/5/2024, 2/6/2024, 2/12/2024, and 2/14/2024. Interview on 2/15/2023 at 11:43 am with LPN HH revealed that the charge nurse completes wound care as ordered when the wound care nurse is not working and documents the care given on the TAR. She stated she does not have any trouble finding time to complete the care assigned to her. She stated if she feels she needs assistance with a task she asks the unit manager for assistance. Interview with LPN NN on 2/15/2024 at 11:49 am revealed the wound care nurse works five days a week, Monday through Friday. She stated the wound care nurse completes all the wound care on the days she is working. She stated on Saturday and Sunday it is the responsibility of the LPN -Charge Nurse to complete and document the wound care completed on the TAR. She stated she has not had trouble completing wound care for residents when working without a wound care nurse. Interview with the DON on 2/15/2024 at 12:14 pm, he confirmed and verified R81's December TAR between 12/13/2023 through 12/31/2023 the nurses documented only three dressing changes for R81's daily sacrum wound dressing changes, January TAR between 1/1/2024 through 1/31/2024 the nurses documented only eight dressing changes, and the February TAR between 2/1/2024 through 2/14/2024 the nurses documented only six dressing changes. He revealed his expectation was that wound care be performed as ordered by the physician and documented on the TAR. He stated he expected the nurse performing the wound care should follow through with the orders and document care and wound care given to the resident in the EMR. He stated he thinks the nurses have been prioritizing patient care over documentation, therefore not documenting the care they have given.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 47146 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Oxygen (O2) Administration, the facility failed to change and date O2 tubing weekly for three of 41 sampled residents (R) (R36, R84, R54), to clean O2 and CPAP (continuous positive airway pressure device) filters for two of 41 sampled residents (R36 and R61), and to have orders for CPAP use for one of 41 sampled residents (R50). Findings include: Review of the facility policy titled Oxygen Administration date reviewed/revised December 2022, revealed under Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences. Under the subsection titled Policy Explanation and Compliance Guidelines revealed under number one: oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as possible when the situation is under control. Section number five revealed under subsection b: staff change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Subsection five, c revealed: Staff change the humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Subsection five, e revealed: Staff keep delivery devices covered in a plastic bag when not in use. Number seven revealed: The cleaning and care of equipment shall be in accordance with the facility policies for such equipment. 1. Review of the electronic medical record (EMR) revealed R36 was admitted to the facility with diagnoses listed but not limited to chronic respiratory failure with hypercapnia. Review of R36's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/5/2024 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates R36 was cognitively intact. Review of R36's care plan indicated a focus of oxygen therapy related to chronic respiratory failure (date initiated on 10/11/2023, created on 12/20/2022 by MDS Coordinator, revised on 10/12/2023 by MDS Coordinator). Goals included but not limited to R36 will have no signs or symptoms of poor oxygen absorption (date initiated 10/22/2023, created 12/20/2022 by MDS coordinator; revision on 1/16/2024 by MDS Coordinator). Interventions included but not limited to administer CPAP/BiPAP setting as ordered at hour of sleep (initiated 10/12/2023), Oxygen setting - Oxygen via nasal cannula (NC) as ordered, humidified (initiated 10/11/2023), and monitor for signs/symptoms of respiratory distress and report to physician as needed: respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, skin color (date initiated 10/11/2023). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EMR revealed physician's orders for R36 included but was not limited to Cleanse CPAP mask and tubing with warm soapy water and dry daily one time a day for obstructive sleep apnea, CPAP maintenance cleanse start date 12/15/2023, CPAP or BiPAP (breathing device with inspiratory and expiratory pressures) 12/8, Oxygen liter flow (for bleed in): four liters per minute (LPM), apply at hour of sleep and remove in morning. Interface type: nasal pillows/mask/full face mask humidification (if appropriate) heated or cool fill humidifier with sterile or distilled water; Oxygen at 4.5 liters per minute via nasal cannula, check oxygen saturation every shift. Observations on 2/13/2024 at 3:43 pm of R36 wearing CPAP, observed the vent on back of the CPAP machine where the filter was located was covered with a grey fuzzy substance, and O2 tubing for humidifier bottle was dated 12/7 and only connected to the humidifier bottle but not the concentrator. The NC tubing was not dated. Observations on 2/14/2024 at 10:42 am of R36 while out of the facility for an appointment, observed CPAP mask stored on top of a dresser behind a fan with a stuffed animal on top of it with the vent on the back of the CPAP machine covered with a grey fuzzy substance, the O2 concentrator (oxygen machine) was on, the NC tubing was missing, and the tubing from the humidification bottle was labeled 12/7. Interview on 2/13/2024 at 3:42 pm with R36 revealed that she had not noticed any staff member cleaning her CPAP mask CPAP machine or changing the tubing for her O2. Interview and observations made on 2/14/2024 at 11:30 am with Unit Manager JJ, he verified and confirmed the vent on back of R36's CPAP machine was covered with a grey fuzzy substance. He verified and confirmed the tubing from the humidifier bottle was dated 12/7. He verified and confirmed the CPAP mask was left on top of R36's dresser behind a fan with a stuff animal on top of it. He stated he was not sure who was responsible for cleaning filters for the CPAP machines. He stated the O2 tubing should be changed every week and labeled with the current date. He revealed the date on the humidifier bottle tubing was the date tubing was changed. He stated the CPAP should be stored inside a clear bag, not on top of the dresser. Review of EMR revealed R84 who was admitted to the facility with diagnoses listed but not limited to acute and chronic respiratory failure, pneumonia, and asthma. Review of R84 quarterly MDS with an ARD of 1/2/2024 revealed a BIMS score of 15, which indicates R84 was cognitively intact. Section O (special treatments, procedures, and programs) revealed she received respiratory therapy seven days during the look back period. Review of R84's care plan indicated a focus of risk for respiratory deficit related to asthma/chronic respiratory failure (initiated 10/19/2022) and oxygen therapy related to ineffective gas exchange (initiated 9/27/2023). The goals included but were not limited to R84 will have no signs or symptoms of poor oxygen absorption (initiated 10/19/2022 & 9/27/2023). Interventions included but were not limited to monitor for signs/symptoms of respiratory distress and report the physician as needed, oxygen settings: oxygen via nasal cannula per physician orders (initiated 9/27/2023) and elevate head of bed (initiated 10/19/2022). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EMR revealed physician's orders for R84 included but was not limited to oxygen tubing change weekly, label each component with date and initials every night shift every Wednesday. Oxygen at three liters per minute via nasal cannula, check oxygen saturation every shift for oxygen use / breathing. Observations on 2/13/2024 at 3:30 pm of R84's O2 tubing not being labeled. Observations on 2/14/2024 at 10:29 am of R84's NC not being labeled. Observations and interview on 2/14/2024 at 11:30 am with Unit Manager JJ, he verified and confirmed the O2 tubing on the O2 concentrator which R84 uses was not labeled with the date it was changed. He stated NC tubing should be changed weekly and dated. Review of the EMR revealed R54 was admitted to the facility with diagnoses listed but not limited to chronic obstructive pulmonary disease (COPD) and asthma. Review of R54 quarterly MDS with an ARD of 12/20/2024 revealed a BIMS score of 15, which indicates R54 was cognitively intact. Section I (active diagnoses) revealed cardiorespiratory conditions and chronic obstructive pulmonary disease (COPD). Section O (special treatments, procedures, and programs) revealed R54 received oxygen therapy. Review of R54's care plan indicated a focus of COPD related to impaired oxygenation (initiated 10/19/2022). Goals included but not limited to R54 will be free of signs / symptoms of respiratory infections. Interventions included but are not limited to monitoring signs / symptoms of acute respiratory insufficiency, monitor and document anxiety, monitor document report signs / symptoms of respiratory infection. Review of the EMR revealed physician's orders for R54 included but not limited to oxygen tubing change weekly, label each component with date and initials, every night shift every Wednesday, oxygen at two liters per minute to keep oxygen saturation greater than 92 percent as needed for breathing (start date 10/2/2022). Observations on 2/13/2024 at 2:55 pm of R54's O2 tubing dated 1/2/2024. Observations on 2/14/2024 at 10:17 am of R54's O2 tubing dated 1/2/2024. Interview and observations made on 2/14/2024 at 11:52 am with Unit Manager JJ, he verified and confirmed the O2 tubing for R54 was dated 1/2/2024 and stated O2 tubing should be changed and dated each week. Interview on 2/15/2024 at 12:14 pm with the Director of Nursing (DON) revealed O2 tubing should be changed weekly and dated, and all respiratory supplies should be stored inside a plastic bag, including but not limited to CPAP, BiPAP masks/tubing's, NCs, and aerosol generating devices. He stated filters for CPAP, BiPAP, and O2 concentrators should be cleaned weekly for dust, grime, and sponge filters should be air dried after cleaning. He stated he expected the nursing staff to adhere to the policies and procedures of the facility. He stated he expected the nursing staff to change and date all respiratory supplies weekly, when they are not in use store in a plastic bag, and clean filters and equipment weekly allowing sponge filters to air dry. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of the EMR for R61 revealed he was admitted to the facility with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, heart failure, and acute on chronic diastolic (congestive) heart failure. A review of the most recent quarterly MDS assessment dated [DATE], revealed R61 had a BIMS score of 15, which indicated resident was cognitively intact. Section O (Special Treatments and Programs) revealed resident received oxygen therapy. A review of a care plan dated 2/13/2024 revealed R61 had a diagnosis of congestive heart failure and respiratory illness and required continuous oxygen therapy. Observations on 2/13/2024 at 10:14 am, during initial screening and at 2:17 p.m. revealed R61 observed out of bed to wheelchair, O2 NC attached to the concentrator lying on the residents bed. The O2 concentrator was on with the flow settings at 2 LPM. The filter on the O2 concentrator had a white/light grey, fuzzy substance over the vent covering the filter, and the humidifier bottle was empty. There was also an O2 cylinder on the back of R61's wheelchair; the NC attached was not properly stored while not in use. Observation 2/14/2024 at 8:26 am revealed R61 out of bed to wheelchair. The O2 cylinder on the back of the wheelchair with tubing hanging was not properly stored while not in use. Further observation revealed R61 wearing O2, and the concentrator was on. The humidifier bottle was now dated 2/13/2024. The vent covering the filter of the O2 concentrator continues to have a white/light grey, fuzzy substance. Observation 2/14/2024 at 10:59 am revealed R61 out of bed to wheelchair. R61 was not wearing O2 at the time of this observation. The O2 concentrator was on, and the attached NC was lying on the floor not properly stored. The O2 cylinder on the back of the resident's wheelchair had a NC attached but was not properly stored while not in use. Observation on 11/4/2023 at 8:56 am revealed the O2 NC tubing was now dated 11/3/2023, the humidifier bottle remained empty, and the O2 concentrator's filter continues to have a white/light grey, fuzzy substance on the entire filter. Interview and walking rounds 12/14/2024 at 11:07 am with LPN Unit Manager AA revealed she was not sure who was responsible for changing or washing the filters on the O2 concentrators, but she would find out. LPN Unit Manager AA further stated that the NCs and all other respiratory tubing should be changed and dated weekly and stored in a clear drawstring plastic bag when not in use. LPN Unit Manager AA verified the fuzzy substance on the vent cover of the filter on the O2 concentrator and the NC were not properly stored while not in use. Interview 2/14/2024 at 12:28 pm with the DON revealed the Certified Nursing Assistants (CNA's) and Nurses are responsible for ensuring the respiratory tubing is stored in a plastic bag when not in use. The DON further stated that the tubing is changed and dated weekly. The DON further stated that the filters are also changed and washed weekly on the night shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview 2/14/2024 at 2:31 pm with R61 revealed the tubing on the O2 concentrator was now bagged in a plastic bag. The filter cover continued to have a white/light grey, fuzzy substance. The tubing on the O2 cylinder on the back of resident's wheelchair was still not bagged while not in use. R61 stated the tubing on the back of the chair was old tubing and it had not been changed in months. R61 further stated that the tubing to the concentrator was changed and placed in the plastic bag today. R61 further stated that he had not witnessed staff cleaning or washing the concentrator filter and she was not aware that the concentrator had a filter. Interview 12/15/2024 at 8:35 am with CNA CC revealed that she was aware that the respiratory tubing should be stored in a plastic bag. She stated that the night shift was responsible. CNA CC stated she had witnessed tubing not in bag while not in use, but she was busy and honestly forgot to do it. A review of the EMR for R50 revealed he was admitted to the facility with diagnoses including but not limited to anxiety disorder and heart failure. A review of an admission MDS assessment dated [DATE], revealed R50 had a BIMS score of 15, which indicated resident was cognitively intact. The initial tour of the facility on 2/13/2024 at 10:13 am revealed a CPAP machine on R50's dresser along the side of his bed. R50 stated he wore the CPAP at night and removed it upon waking each morning. R50 stated he has had the machine since admission to the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47146 Based on observations, staff interviews, record review, and review of the facility policy titled, Use of Psychotropic Medication, the facility failed to indicate a 14 day stop date for psychotropic medication for one of 41 sampled residents (R) (R35) and failed to ensure one of 41 sampled residents (R22) was evaluated for use of as needed (PRN) psychiatric medications beyond 14 days. Findings include: Review of the facility policy titled Use of Psychotropic Medication date reviewed/revised August 2023, revealed under Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medication(s). Under the subheading titled Policy explanation and Compliance Guidelines revealed under: PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). Number 9 a revealed: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. Review of the electronic medical record (EMR) revealed R35 was admitted to the facility with diagnoses listed but not limited to Alzheimer's disease and dementia. 1. Review of R35's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/3/2024 revealed she had short- and long-term memory problems and her cognitive skills for daily decision making was severely impaired. Section J (health and conditions) revealed she received pain management and had a condition or chronic disease that may result in a life expectancy of less than six months. Section N (Medications) revealed she was receiving antipsychotics and antidepressants. Review of R35's care plan indicated a focus of a diagnosis of a major neurocognitive disorder and is experiencing disturbed thought processes secondary to grief, sleep, appetite and anxiety initiated on (10/20/2022 by the MDS coordinator). The goals included but not limited to the indication of the resident will demonstrate decreased signs and symptoms such as sadness, tearfulness, hopelessness, anger, loss of interest, in preferred activities, sleep disturbance overwhelming fatigue, increased/decreased appetite, increased complaints of pain (initiated on 10/20/2022 by the MDS coordinator). Interventions included but were not limited to administering medications as ordered. Monitor/document the side effects and effectiveness (date initiated 10/20/2022 by the MDS Coordinator). (continued on next page)

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	115206	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marietta Center for Nursing and Healing	811 Kennesaw Avenue Marietta, GA 30060

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Electronic Medical Record (EMR) revealed physician's orders for R35 included but was not limited to Ativan (lorazepam) oral tablet, a medication used to relieve anxiety. The dosage ordered was one milligram (mg) every four hours as needed (PRN) for anxiety. The start date was documented as 2/7/2024 at 1:15 pm. The stop date was documented as indefinite. Interview on 2/15/2024 at 10:39 am with the Director of Nursing (DON), he confirmed and verified the order dated 2/7/2024 at 1:15 pm for Ativan one mg every four hours as needed was started on 2/7/2024 and the stop date was documented in the orders as indefinite, indicating no stop date. He stated unless the nurse knows that antipsychotics should have a stop date of 14 days, they will not know to question the physician. He stated he suspected the order was written with an indefinite stop date because the resident was on hospice. 2. Review of the EMR for R22 revealed the resident had a diagnosis including but not limited to anxiety disorder, depression, and repeated falls. Review of R22's discharge orders from the hospital revealed an order for alprazolam oral tablet 0.25 milligram (mg), give one tablet by mouth two times a day as needed for anxiety up to five days. Review of the Physician orders for R22 revealed a medical doctor's (MD) order for alprazolam 0.25 milligram (mg) by mouth every 12 hours as needed for anxiety. The order had a start date of 1/29/2024, but the order had no stop date. Review of a practitioner progress note dated 2/1/2024 revealed a list of R22's current medications to include Alprazolam Oral Tablet 0.25 MG, give 1 tablet by mouth every 12 hours as needed for ANXIETY, 0.25MG, ACTIVE, 1/29/2024 to. (This sentence in the progress note was incomplete to contain a stop date). Interview on 2/14/2024 at 10:12 am with Licensed Practical Nurse (LPN) BB revealed R22 does not have a current order for alprazolam because the doctor did not renew the order, the last she heard. LPB BB opened the locked box on the medication cart, removed the blister pack of alprazolam and stated the medication is here, it came in. Observation on 2/14/2024 at 10:14 am of the medication cart revealed R22 had a blister pack containing 27 tabs of alprazolam dispensed from the pharmacy on 2/13/2024. One tablet had been removed from the blister pack. Review of the Narcotic Control Sheet on the medication cart revealed 28 tablets were received on 2/13/2024. On 2/14/2024 at 1:00 am, one tab was documented on the narcotic log as administered with 27 tablets remaining. Interview on 2/14/2024 at 12:02 pm with Unit Manager LPN AA revealed she was not aware that PRN psychotropic medications could only be ordered for 14 days and were required to be re-evaluated by the physician and reordered if it was still needed. LPN AA verified R22 did not have documentation in the record related to continuing the alprazolam past the 14-day duration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/14/2024 at 12:28 pm with Director of Nursing (DON) revealed that PRN psychotropic medications are ordered for 14 days. The DON further stated the physicians, and the Nurse Practitioner (NP) are responsible for making sure those orders are addressed. The DON further stated that nurses don't do anything related to the PRN psychotropic medication orders. The DON confirmed that there was Haldol, and the original lorazepam order had been onboard for longer than 14 days without sufficient documentation regarding a rationale and duration for continued use of the medication. In addition, the DON stated LPN AA probably would not be aware of the policy related to PRN psychotropic drug usage. Interview 2/14/2024 at 1:00 pm with Medical Director revealed he is aware that PRN psychotropic medications are prescribed for up to 14 days and after that time he or the NP are responsible to re-evaluate the resident to see if continued use is warranted for the medication. If continued use is warranted, a new order is written with a duration and the reason for the continuation of the medication. The MD further stated that the nurse should inform him when a resident needs to be re-evaluated for psychotropic medications.

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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. 47146 Based on observations, staff interviews, record review, and review of the facility policies titled, Hand Hygiene, PPE Source Control, Standard Precautions Infection Control, and Infection Prevention and Control Program, the facility failed to utilize personal protective equipment (PPE) properly in an isolation room for one of one resident (R) (R95) on transmission based precautions and failed to perform hand hygiene between residents when delivering resident meals to resident rooms for seven of eight residents on the East-C hall. The deficient practice had the potential to spread infection to other residents and staff. The facility census was 127 residents. Findings include: Review of the facility policy titled Hand Hygiene date reviewed/revised June 2023 revealed under Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Under the section titled Policy Explanation and Compliance Guidelines number one revealed staff will perform hand hygiene when clinically indicated, using proper technique consistent with acceptable standards of practice. Number three revealed alcohol-based hand rub with 60 - 95 percent alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom. Review of the facility policy titled PPE Source Control date reviewed/revised December 2022 revealed under Policy: The facility promotes appropriate use of personal protective equipment (PPE) to prevent the transmission of pathogens to residents, visitors, and other staff. Review of the facility policy titled Standard Precautions Infection Control date reviewed/revised 9/12/2022 revealed: All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to Standard Precautions to prevent the spread of infection to residents, staff and visitors. Under the subheading Policy Explanation and Compliance Guidelines revealed number two (a): Using personal protective equipment (PPE) revealed all staff who have contact with residents and or their environments must wear PPE as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. Number two (b) revealed: Multiple factors determine the appropriate selection of PPE for a particular task. Refer to the facilities Personal Protective Equipment Policy for indications and considerations for use of PPE. Review of the facility policy titled Infection Prevention and Control Program date reviewed/revised May 2023 revealed under Policy: The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Under the sub-heading titled Policy Explanation and Compliance Guidelines, number two revealed: All staff are responsible for following all policies and procedures related to the program. Number five: isolation protocol (transmission-based precautions) revealed: A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by the current CDC [Centers for Disease Control and Prevention] guidelines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Observation on 2/14/2024 at 1:17 pm of Certified Nursing Assistant (CNA) PP performed hand hygiene prior to delivering and setting up the first tray for residents on the East-C Hall. She then delivered trays to another seven of eight residents on the hall but did not perform hand hygiene between each tray that was delivered to the residents. Interview with CNA PP on 2/14/2024 at 1:22 pm, she stated she utilized hand sanitizer once prior to delivering the first tray on the East-C Hall. She stated she did not use hand sanitizer, nor did she wash hands with soap and water between delivering each tray. She stated she was the only staff passing trays and she had to get them to the residents as soon as possible. She stated the dietary staff had delivered trays to the unit she was assigned to (East-B Hall) and she had to go so she could deliver trays to residents on the East-B Hall. Interview on 2/14/2024 at 2:00 pm with Unit Manager JJ revealed that staff should perform hand hygiene between delivering and setting up each resident's meal tray. He stated he expected the CNAs to perform hand hygiene either utilizing soap and water or hand sanitizer between delivering each tray to a resident. Interview on 2/15/2024 at 12:14 pm with the Director of Nursing (DON) revealed that staff should perform hand hygiene before delivering and between each tray delivered utilizing hand sanitizer if they choose or soap and water, but they should use soap and water every third time they need to perform hand hygiene. He stated his expectation was that they perform hand hygiene before delivering meal trays and between each meal tray delivered to residents. 2. Observation on 2/13/2024 at 12:58 pm on hall E revealed CNA FF went into room E2 without PPE for droplet/contact precautions. Supplies were available for staff located on the door which included face mask, gowns, and gloves. Face shields were not available at the time that CNA FF entered the room. The procedure for wearing PPE was on the front door including how to enter and exit the room. CNA FF entered the room to deliver lunch to R95. CNA FF did not put on a gown, gloves or face shield. She did not remove the face mask once she exited the resident's room. She sanitized her hands. She entered other residents' rooms to deliver lunch with the same face mask on. Interview on 2/13/2024 at 1:05 pm on Hall E, CNA FF revealed that she never puts on PPE when entering resident R95's room to deliver lunch. Interview on 2/13/2024 at 1:15 pm with the DON revealed that all staff had been trained on using PPE equipment for droplets/ contact precautions. 49681