STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115670	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockdale Healthcare Center	1510 Reniassance Drive Conyers, GA 30012

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272 Based on observations, resident and staff interviews, record review, and review of the facility policy titled Self-Administration of Medication, the facility failed to adequately assess one of 50 sampled residents (R) (R24) for self-administration of medication. This failure placed R24 at risk for inappropriate and unsafe medication use. Findings Include: A review of the facility policy titled Self-Administration of Medication, dated 4/2022, revealed the Policy was, The purpose of this procedure is to establish uniform guidelines concerning the self-administration of drugs. The General Guidelines section included 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team. A review of R24's electronic medical record (EMR) revealed diagnoses including, but not limited to, cognitive-communication deficit, dementia, major depressive disorder, mild cognitive impairment, psychotic disturbance, mood disturbance, and anxiety. A review of R24's Quarterly Minimum Data Set (MDS) dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 9 (indicating moderate cognitive impairment). A review of R24's care plan dated 9/21/2024 for R24 revealed a care plan area for knowledge deficit, impaired cognitive function, and some short-term memory deficits. Further review revealed there was no care plan area for self-administration of medication. A review of R24's active Physicians Orders revealed no orders were found for the medication zinc oxide ointment (a topical medication used for skin protection). Observation on 10/29/2024 at 10:59 am in R24's room revealed two boxes of zinc oxide ointment on the resident's bedside table. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 10:22 am, Registered Nurse/Unit Manager (RN/UM) VV stated residents were not permitted to have medications at their bedside. RN/UM VV explained that, typically, if staff found medication at the bedside, it would be removed and given to the nurse. RN/UM VV further stated when self-administration of medications was considered, the resident had to be assessed for cognitive ability, complete a return demonstration, and obtain approval from the doctor. RN/UM VV stated when a physician's order was updated, the physician could specify which residents were allowed to self-administer medications, and this information would be reflected on the MAR (Medication Administration Record). RN/UM VV further stated that Certified Nursing Assistants (CNAs) were expected to routinely check for medications at the bedside daily, although they didn't typically conduct formal sweeps. She further stated if medication was found at the bedside, it should be reported to the charge nurse or unit manager. RN/UM VV also stated that leaving medication at the bedside could lead to potential risks such as contraindications with other medications, overdose, or various adverse side effects, depending on the medication. During an interview on 10/31/2024 at 10:58 am, the Director of Nursing (DON) confirmed that a physician's order must be in place before allowing medications at the bedside. Additionally, the DON stated a self-administration for medication assessment must be conducted, and the medication must be stored in a locked box. The DON further explained that one of the potential negative outcomes of allowing medications at the bedside was the risk of a roommate accessing the medication or improperly applying it, such as with topical creams. During an interview on 10/31/2024 at 11:00 am, the Administrator confirmed that a self-administration of medication assessment and a physician's order was required for a resident to keep medication at the bedside. The Administrator emphasized that, to his knowledge, no residents were currently authorized to self-administer medications. The Administrator stated that it was the expectation of the nursing staff to check for medications at the bedside daily and if any are found, they are to be removed immediately.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37650 Based on staff interviews and record review, the facility failed to ensure notifications of discontinuation of Medicare Part A benefits were issued in a timely manner for three of three residents (R) (R36, R81, and R605) reviewed for beneficiary notification. This failure had the potential to result in a lack of understanding of appeal rights and/or the termination of the current level of care against the resident's/representative's wishes. Findings include: 1. Review of R36's Part A Discharge Minimum Data Set (MDS) assessment dated [DATE] revealed section A (Identification Information) documented the Medicare stay had a start date of 7/1/2024 and an end date of 8/17/2024. Review of R36's Occupational Therapy Discharge Summary dated 5/11/2024 to 8/16/2024 revealed R36 had reached her maximal potential and was discharged to long-term care at this facility. The Occupational Therapist (OT) signed the note on 8/21/2024. Review of R36's medical record revealed no evidence that a (Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage) SNF-ABN form or a (Notice of Medicare Non-Coverage) NOMNC form was provided before discharge from Medicare Part A on 8/16/2024. The facility provided a NOMNC form that was signed and dated 6/13/2024. 2. Review of R81's Part A Discharge MDS assessment dated [DATE] revealed section A (Identification Information) documented the Medicare stay had a start date of 6/1/2024 and an end date of 8/6/2024. Review of R81's Occupational Therapy Discharge Summary dated 4/30/2024 to 8/6/2024 revealed R81 was discharged from therapy on 8/6/2024. The document was signed by the OT on 8/7/2024. Review of R81's medical record revealed no evidence that an SNF-ABN form or a NOMNC form was provided before discharge from Medicare Part A on 8/6/2024. The facility provided a NOMNC form that was signed and dated 5/30/2024. 3. Review of R605's Discharge MDS assessment dated [DATE] revealed Section A (Identification Information) documented discharge from the facility on 6/1/2024, return not anticipated, planned discharge, and the end of the most recent Medicare stay was 6/1/2024. Review of R605's Occupational Therapy Discharge Summary dated 5/15/2024 to 5/31/2024 revealed R605 had reached his maximum potential with skilled services. The document was signed by the OT on 5/31/2024. Review of R605's medical record revealed no evidence that a NOMNC form was provided before discharge from Medicare Part A on 5/31/2024. The facility provided a NOMNC form that documented services ended on 3/17/2024. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/31/2024 at 9:34 am, the Business Office Manager (BOM) confirmed R36 was discharged from Medicare Part A Services on 8/18/2024, R81 was discharged from Medicare Part A services on 8/7/2024, and they remained in the facility after discharge from Medicare Part A services. She further confirmed R605 was discharged from Medicare Part A services on 6/1/2024 and discharged to home on 6/1/2024. She stated she does not issue NOMNC or SNF-ABN forms to residents. In an interview on 10/31/2024 at 9:45 am, the Social Services Director (SSD) confirmed R605, R81, and R36 were discharged from Medicare Part A due to meeting their individual therapy goals. She stated Medicare Part A residents should receive both a NOMNC and SNF-ABN notification approximately three days prior to discharge from Medicare Part A services. She confirmed R605 should have received a NOMNC three days prior to his discharge on 6/1/2024. She confirmed the facility did not provide a NOMNC prior to his discharge on 6/1/2024, and the only NOMNC he received was dated 3/15/2024. She further confirmed the NOMNC and SNF-ABN forms should have been completed and provided to R36 and R81 two to three days prior to their most recent discharge from Medicare Part A services. In an interview on 10/31/2024 at 10:20 am, the Administrator revealed the team was new, and his expectation was the SSD should be providing the NOMNC and SNF-ABN to residents prior to their discharge from Medicare Part A services. He further stated possible outcomes of not providing the notifications were that the residents could possibly be billed for services not covered during that time. He stated he expected staff should make sure everything was provided, signed, and dated appropriately.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37650 Based on observations, staff interviews, record review, review of the facility policy titled Environmental Services, and review of the manufacturer recommendations titled Monthly Maintenance Front Filters, the facility failed to maintain a clean, homelike environment by not ensuring that packaged terminal air conditioner (PTAC) filters were free of debris in 2 of 42 resident rooms. This failure had the potential to compromise the hygiene and safety of the room environments, increasing the risk of infection and negatively impacting the health and well-being of the residents residing in the rooms.The census was 103 residents. Findings Include: Review of the facility policy titled Environmental Services, dated 4/2022, revealed the Policy stated, It is the primary responsibility of the Housekeeping, Laundry and Maintenance Departments to ensure a safe, sanitary, orderly and comfortable environment. The Policy Interpretation and Implementation section included . 2. Preventative maintenance will be conducted. 7. A safe, clean, comfortable, and homelike environment will be provided. Review of the facility-provided manufacturer recommendations titled Monthly Maintenance Front Filters documented, One of the most important things you can do to maintain your PTAC units is clean the air filters at least once a month, or more often in a new facility or one with new carpeting. Observation on 10/29/2024 at 10:30 am in room [ROOM NUMBER] revealed the PTAC filters to have a thick layer of white, fuzzy substance. Observation on 10/29/2024 at 1:28 pm in room [ROOM NUMBER] revealed the PTAC filters to have a thick layer of white, fuzzy substance. During an interview on 10/31/2024 at 9:36 am, Housekeeper UU revealed maintenance was responsible for cleaning the air filters, and she was unsure how often they were cleaned. During an observation on 10/31/2024 at 9:39 am, the Maintenance Director (MD) confirmed the PTAC filters in room [ROOM NUMBER] had a thick layer of white, fuzzy substance. During an interview on 10/31/2024 at 11:02 am, the Administrator stated that the PTAC filters should be checked monthly. The Administrator emphasized that the expectation was for the filters to be cleaned regularly to ensure good air quality. Furthermore, the Administrator noted that poor air quality could result in negative outcomes, such as respiratory issues for residents. 50272

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579 Based on observations, interviews, record review, and review of facility's policy titled Resident Assessment, the facility failed to ensure that all high-risk medications were coded on the admission assessment for one of 50 sampled residents (R) R309. This deficient practice had the potential to cause resident not to receive person centered care. Findings include: Review of the undated facility's policy titled Resident Assessment, under the section titled Intent revealed, It is the policy of the facility to provide, and services related to Resident Assessment/Instrument and process in accordance with State and Federal regulation. Under the section titled Procedure revealed, This policy will include: 1. Admission Physician orders for Immediate care .7. Accuracy of Assessments. Review of the Electronic Medical Record (EMR) for R309 revealed, she was admitted with diagnoses that included but were not limited to acute respiratory failure, acute embolism and thrombosis of deep veins or right lower extremity, sepsis due to streptococcus pneumoniae, chronic combined systolic and diastolic heart failure. Review of physician orders revealed R309 had orders that included vancomycin intravenous solution (IV antibiotic) with start date of 10/28/2024, furosemide (diuretic) with start date of 10/18/2024, oxycodone-acetaminophen (pain medication) with start date of 10/7/2024, and apixaban (anticoagulant) with start date of 10/7/2024. Review of the 5 (five)-day admission Minimum Data Set (MDS) dated [DATE] for Section N (Medications) revealed that the resident was taking high risk medications that included diuretic, opioid, and a hypoglycemic medication as a resident. There was no indication that the resident was taking an anticoagulant. Interview on 10/31/2024 at 5:55 pm with MDS Director BBB revealed, care plans are updated and reviewed quarterly with assessments, and during Intradisciplinary Team (IDT), Patients at Risk (PAR) and clinical meetings. She also revealed, that the MDS assessment information is received from the resident's profile, clinical and PAR meeting, Patient-Drive Payment Model (PDPM) meeting, nurses' notes, medication administration record (MAR), therapy notes, hospital records, and documentation. The 5-day assessment is to be completed by day 8 from admission and transmitted by day 14. They will have until Day 20 if it includes the admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579 Based on observations, staff interviews, record review, and review of the facility policy titled Care Plan -Comprehensive, the facility failed to develop a comprehensive person-centered care plan that addressed all high-risk medications for two of 50 sampled residents (R) (R309 and R83). This failure had the potential for residents to not receive treatment and/or care according to their needs. Findings include: Review of the facility policy titled Care Plan-Comprehensive, dated January 2023, revealed the Policy stated, A comprehensive care plan that includes measuring objectives and timetables to meet the residents medical, nursing, mental and psychological needs shall be developed for each resident. The Policy Interpretation and Implementation section included 2. The Comprehensive Care Plan has been designed to do the following but was not limited to b. Incorporate risk factors associated with identified problems; d. Reflect treatment goals and objectives in measurable outcomes. 4. Care plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly. 1.Review of the Electronic Medical Record (EMR) for R309 revealed, that she was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure, acute embolism and thrombosis of deep veins or right lower extremity, sepsis due to streptococcus pneumoniae, chronic combined systolic and diastolic heart failure. Review of physician orders revealed R309 had orders that included but not limited to (diuretic) with start date of 10/18/2024, oxycodone-acetaminophen (pain medication) with start date of 10/7/2024, and apixaban (anticoagulant) with start date of 10/7/2024 and O2 (oxygen) 2L (two liters) NC (nasal cannula) continuous. Review of R309's care plan dated 10/8/2024 revealed, there were no care plans with interventions that addressed the risk for diuretic and anticoagulant medications or the use of oxygen. Interview on 10/31/2024 at 5:35 pm with Infection Preventionist (IP) TT revealed, that any nurse can update the care plan. Interview on 10/31/2024 at 5:55 pm with Minimum Data Set (MDS) Director BBB revealed, care plans are updated and reviewed quarterly with assessments, and during Intradisciplinary Team (IDT), Patients at Risk (PAR) and clinical meetings. 37650 2. Review of EMR for R83 revealed, he was admitted to the facility with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and muscle weakness. Review of R83's MDS assessment dated [DATE] revealed Section C (Cognitive Pattern) a Brief Interview for Mental Status (BIMS) of 14, which indicated little to no cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of EMR for R83 revealed physician's orders that included but not limited to, valsartan oral tablet 80 mg (milligram), melatonin oral tablet, buspirone hcl oral tablet 15 mg, and duloxetine hcl (hydrochlorothiazide) oral capsule delayed release sprinkle 60 mg. Review of R83's care plan dated 9/14/2024 revealed there was no care plans that addressed psychotropic medication usage. During an interview on 10/31/2024 at 3:46 pm the Director of Nursing (DON) confirmed there was no comprehensive care plan for R83s psychotropic medications. The DON revealed she was not aware there was no care plan for R83s psychotropic medications and that the MDS and Social service department was responsible for ensuring the care plans were developed and updated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50526 Based on observations, staff and interviews, record review, and review of the facility's policies titled Activities of Daily Living (ADLs)/Maintain Abilities, and Care of Fingernails, the facility failed to ensure that Activities of Daily Living (ADL) was provided for two of three residents (R) R72 and R83 reviewed for ADL. Findings include: Review of the facility's undated policy titled Activities of Daily Living (ADLs)/Maintain Abilities under the section titled Intent revealed, It is the facility's responsibility to ensure all staff understand the principles of quality of life and honor and support these principles for each resident; and that the care and services provided are person-centered. Under the section titled Procedure revealed, 3. The facility will provide care and services for the following activities of daily living, hygiene which is bathing dressing, grooming and oral care. 4. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal hygiene Review of the facility's policy titled Care of Fingernails, dated April 2022 under the section titled Steps in the Procedure revealed, 7. Gently, remove the dirt from around and under each nail with an appropriate device; 8. Trim fingernails in an oval shape straight across; 9. Smooth the nails with a nail file or emery board, if necessary. Apply lotion if requested; 10. Repeat the procedure for the second hand. Review of the Electronic Medical Record (EMR) for R72 revealed he was with diagnoses that included but not limited to aphasia, cognitive social deficit following intracerebral hemorrhage, type 2 diabetes mellitus and dementia. 1. Review of R72's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C (Cognitive Pattern) a Brief Interview for Mental Status (BIMS) of three, which indicated severe cognitive impairment; Section GG (Functional Status) revealed, R72 was dependent for ADLs with one or more-person assistance. Observation on 10/29/2024 at 11:04 am revealed, R72 fingernails were dirty with dark debris underneath them. Observation on 10/30/2024 at 1:20 pm revealed R72 was feeding himself with his hands and his fingernails remained dirty with dark debris underneath them. Interview with R72's family on 10/30/2024 at 1:22 pm revealed his nails were usually dirty. R72 family revealed, that she would wash his hands when she came to visit but did not have anything to clean his nails and that she expected staff to provide nail care. Interview on 10/30/2024 at 1:50 pm with Certified Nursing Assistant (CNA) GG revealed residents were bathed three times per week which included hair care, face care and nail care that should be completed during this time. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/30/2024 at 1:50 pm with CNA HH revealed residents are bathed three times per week which includes hair care, face care, foot care and nail care that should be completed during this time. Interview on 10/30/2024 at 2:01 pm with Licensed Practical Nurse (LPN) BB confirmed all residents should be provided with nail care during every bath time except for diabetic residents. Interview on 10/30/2024 at 2:05 pm with the Director of Nursing (DON) confirmed expectations for every resident to receive nail care with each bath as per policy. 37650 2. Review of EMR for R83 revealed, he was admitted to the facility with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and muscle weakness. Review of R83's MDS assessment dated [DATE] revealed Section C (Cognitive Pattern) a Brief Interview for Mental Status (BIMS) of 14, which indicated little to no cognitive impairment; Section GG (Functional Status) revealed, R83 had impairment on one side and was dependent for ADLs with one or more-person assistance. Observation and interview on 10/29/2024 at 1:04 pm revealed, R83 sitting up in bed preparing to eat lunch. R83's fingernails were long and dirty with dark debris underneath them. He revealed, staff did not offer R83 a wipe, washcloth or hand sanitizer before eating. Interview on 10/29/2024 at 1:04 pm with R83 revealed, he was not aware that staff could trim his nails and clean underneath them. R83 reported his family member provided his nail care. During an interview on 10/31/2024 at 3:52 pm the Director of Nursing (DON) revealed that the nursing staff was responsible for making sure R83s nails were clean and free of debris. DON revealed nail care was a part of ADL care and should be completed.

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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** 50877 Based on observations, resident, resident family and staff interviews, record review, and review of the facility's policies titled, Medication Administration and Activities of Daily Living (ADLs)/Maintain Abilities, the facility failed to give ordered medications that were readily available for one of 50 sampled residents (R) (R553) and failed to implement resident-directed care and treatment consistent with the resident's orders as directed by podiatrist and professional standards of practice for one of 50 sampled R (R50). The deficient practices had the potential to cause R553 to be at risk for medical complications, unmet needs, and a diminished quality of life and cause pain and possible open skin which can lead to infection for R50. Findings include: Review of the facility policy titled Medical Administration dated April 2022 revealed under Policy Interpretation and Implementation: 8. Unless otherwise specified by the resident's attending physician, routine drugs should be administered as scheduled. Review of the facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities not dated, revealed under Intent: It is the facility's responsibility to ensure all staff understand the principles of quality of life and honor and support these principles for each resident; and that the care and services provided are person-centered. Under Procedure revealed: 3. The facility will provide care and services for the following activities of daily living, hygiene which is bathing dressing, grooming and oral care. 4. Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene. 1. Review of the electronic medical record (EMR) for R553 revealed that she was admitted with diagnoses that included but were not limited to chronic obstruction pulmonary disease (COPD), and chronic respiratory failure with hypoxia. R553 requires 3 liters per minute (LPM) of oxygen, related to diagnoses. Review of the admission Minimum Data Set (MDS) for dated 11/1/2024 for R553 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Interview on October 29, 2024, at 3:59 pm with R553, her son, and her Homecare Aide revealed that the resident had not received her medications. It was revealed that she had not received her night and the following morning medications. The son showed that he brought R553's home medications in hopes that the staff would administer her medications. The son and the Homecare Aide stated that they did inform Registered Nurse (RN) RR. Review of the physician's orders revealed that R553 medications included: albuterol sulfate, atorvastatin, Eliquis, furosemide, levothyroxine, lorazepam, losartan, and Spiriva. An interview on 10/30/2024 at 10:29 am with RN RR confirmed and verified that R553 did not receive night and morning medications. She explained that because the resident arrived late in the afternoon that the pharmacy could not dispense the medication as ordered. Also, she would need the Director of Nursing's (DON) approval for the resident to be given home medications. (continued on next page)

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	115670	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockdale Healthcare Center	1510 Reniassance Drive Conyers, GA 30012

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/30/2024 at 11:41 am with the DON revealed that the facility does have an emergency medication machine. Home medications, if brought to her attention, could be administered after she received an order from the provider. The DON stated that she did not know about the home medication being available or that the ordered medications were not given. 50526 2. Review of the EMR revealed R50 was admitted to the facility with diagnoses including but not limited to malignant neoplasm of colon, hypertension, schizophrenia, and dementia without behavioral disturbance. Review of R50s quarterly MDS assessment dated [DATE] revealed a BIMS score of 00, which indicates R50 was identified to have severe cognitive impairment. Section GG (Functional Status) revealed R50 required maximum assistance for ADLs with two or more-person assistance. Section M (Skin Conditions) did not identify dry scaly skin on both feet. Review of R50s care plan dated 10/7/2024 indicated a problem of potential impairment to skin integrity related to fragile skin, incontinence of bowel and bladder, impaired mobility, history of pressure ulcers. Goals included but not limited to: resident will be free from injury through the review date. Interventions included but not limited to avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Keep skin clean and dry. Use lotion on dry skin. Additional problem identified ADL Self Care Performance Deficit r/t (related to) dementia, limited mobility and limited range of motion. Goals included but not limited to improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene, ADL through the review date. Interventions included but not limited to explain all procedures/tasks before starting. Skin inspection: R50 requires skin inspection. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Check nail length and clean on bath day and as necessary. Report any changes or necessity for trimming to the nurse. Review of the Physician's Orders for R50 included but was not limited to: Order dated 1/24/2024- podiatry to evaluate and treat mycotic nails, ingrown nails, calluses, abscesses, xerosis, cellulitis, toe contusion, granuloma and foot deformities. Order dated 10/16/2024- amlodipine oral tablet two and a half milligrams (mg) daily for high blood pressure. Order dated 10/17/2024- pepcid oral tablet 20 mg at bedtime for gastric reflux. Order dated 6/21/2023- quetiapine fumarate oral tablet 25 mg at bedtime related to schizophrenia. Order dated 12/27/2023- seroquel oral tablet 25 mg tablet in the morning for schizophrenia and behavioral outbursts. Order dated 12/17/2023- vitamin D3 one and one quarter mg oral tablet weekly. (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 Podiatry Consultation Note dated 10/18/2022 revealed routine nail care visit for thickened toenails and recommendation for moisturizer to lower limbs every week. Review of Podiatry Consultation Note dated 8/17/2023 revealed routine nail care and foot scrub once a week with warm, soapy wash cloth to remove dead skin throughout the feet and then moisturizer to lower limbs every week. Review of Podiatry Consultation Note dated 5/15/2024 revealed routine nail care and foot scrub once a week with warm, soapy wash cloth to remove dead skin throughout the feet and then moisturizer to lower limbs every week. Review of Podiatry Consultation Note dated 8/1/2024 revealed routine nail care and foot scrub once a week with warm, soapy wash cloth to remove dead skin throughout the feet and then moisturizer to lower limbs every week. Observation and interview on 10/29/2024 at 9:48 am with R50 revealed a frail gentleman lying in bed on back with the head of the bed slightly elevated. He was verbally responsive repeatedly saying my legs and pointing. R50 then reached down and pulled the covers away from his feet and lower legs revealing thin legs with shiny, reddened and dry skin, both feet very dry with large, thick, flaking skin. R50 did not add any information regarding pain as he was difficult to communicate with and unable to answer specific questions. Observation and interview conducted on 10/31/2024 at 9:35 am of R50 revealed staff member at bedside speaking with him. He responded when spoken to and was smiling. Staff member pulled the covers back and R50s feet were both nearly free of skin flaking and when R50 was asked if he felt better, he nodded his head repeatedly. Interview on 10/29/2024 at 2:33 pm with R50's family representative revealed he had asked for a podiatrist to come see R50 numerous times and had never heard back about it. He also stated R50 had not been out of bed for about one- and one-half years, he can move but his hands are crumpled, so when he visits, he tries to work with his hands to keep them moving. It was also revealed that R50 did have therapy but not in a long time. An interview on 10/30/2024 at 11:05 am with Licensed Practical Nurse (LPN) II revealed R50 had been treated by the wound treatment team for pressure ulcers before, but only had some redness and the team was not treating any other conditions. An interview on 10/30/2024 at 11:12 am with Certified Nursing Assistant (CNA) JJ revealed she does care for R50, and he received bed baths. Her process was to tell him what she would be helping with, started with washing the face and moved down, she saved his feet for last, washing them off carefully and puts on skin protection cream. CNA JJ further revealed R50's feet had been like this for a long time, and they were not getting better, and she has reported to the nurses a long time ago, unable to remember dates or exactly who she told. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/30/2024 at 11:18 am with LPN KK revealed she was a regular nurse on tR50's unit for more than one year and she had not been notified of any orders for skin care for his feet and she was aware they were very dry and flaky. She also confirmed this should be addressed. LPN KK viewed Podiatry Notes in the EMR and confirmed these recommendations should have been put into place and would have been if she had seen them. She then revealed the podiatrist did not provide any information for the care plan when visits at facility were completed and notes were sent later, but the nurses did not get them to review. Interview on 10/30/2024 at 12:25 pm with the Social Service Director (SSD) revealed she did assist with podiatry scheduling and received progress/visit notes back from the provider's office. The SSD further stated if there were orders, these were given to the nursing staff to initiate. If no orders were present, documents were sent to be scanned into the resident chart. The SSD viewed podiatry notes in the EMR and did not see any physician orders but did acknowledge there were treatment orders the nurses should be seeing. The SSD also added if she gave them to the nurse to review, she documented a communication stating this was done. An interview on 10/30/2024 at 2:07 pm with the Director of Nursing (DON) revealed expectations for the process when residents have been seen in house by a provider was that progress/consult notes come back to the SSD and then placed in her in-box so they could be reviewed. The DON would then pass these to the Unit Managers for review and ensure information was shared with the Nurses. The DON also shared any item in the plan of care was to be considered an order without exception and should be carried out by the nursing staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50877 Based on observations, staff interviews, record review, and review of the facility policy titled Administration of Drugs, the facility failed to administer oxygen to one of five residents (R) (R28) who received oxygen and failed to secure the oxygen canister. The deficient practice had the potential to place R28 at risk of respiratory complications. Findings include: Review of the facility policy titled Administration of Drugs, dated April 2022, revealed the Policy stated, Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's Medical Director. Review of R28's electronic medical record (EMR) revealed diagnoses included, but not limited to, chronic obstruction pulmonary disease (COPD) and chronic respiratory failure with hypoxia. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section GG (Functional Abilities and Goals) documented impairment on both sides of upper extremities, and Section O (Special Treatments and Programs) documented oxygen was not used. Review of R28's Physician Orders revealed an order dated 12/27/2023 for oxygen at 3 liters per minute (LPM) continuously via nasal cannula. An observation on 10/29/2024 at 3:50 pm revealed Licensed Practical Nurse (LPN) RR administering oxygen at 1 LPM to R28. LPN RR was observed to adjust the oxygen to 2 LPM. Further observation revealed the oxygen canister was sitting on the floor next to the resident's bed and not secured. During an interview on 10/29/2024 at 3:55 pm, LPN RR confirmed R28's oxygen was not being administered as ordered by the physician and confirmed the oxygen canister was sitting on the floor unsecured. During an interview on 10/30/2024 at 11:37 am, the Director of Nursing (DON) stated oxygen should be administered as ordered.

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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. 50272 Based on observations, record review, staff interviews, and review of the facility's policy titled, Psychopharmacologic Drugs, the facility failed to add a 14-day stop for as-needed (PRN) psychotropic medication for one of five residents (R) (R10) reviewed for unnecessary psychotropic medication. The deficient practice had the potential to affect the resident's highest practicable mental, physical, and psychosocial well-being. The facility census was 103 residents. Findings include: Review of the facility policy titled Psychopharmacologic Drugs dated April 2022, documented under section titled, Policy, The purpose of this procedure is to provide guidelines for the psychopharmacologic drug treatment of a resident with a specific condition as diagnosed and documented in the clinical record. Under section titled, Procedural Guidelines, it documented, 1.Psychopharmacologic drugs include antianxiety agents, antidepressants, sedatives, hypnotics, antipsychotics and other drugs that affect behaviors. 9. PRN orders for psychotropic drugs are limited to 14 days. Excluding Antipsychotic medications, 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 should document their rationale in the resident's medical record and indicate the duration for the PRN order. Under section titled, Unnecessary Drugs it documented, 1.Each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are any drugs when used: a. In excessive dose (including duplicate drug therapy) b. For excessive duration. c. Without adequate monitoring. d. In the presence of adverse consequences that indicate the dose should be reduced or discontinued. 2. PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. A review of electronic health record (EHR) for R10 revealed diagnoses including but not limited to acute or chronic diastolic (congestive) heart failure, Alzheimer's Disease (unspecified), dementia in other disease classified elsewhere (unspecified severity without behavioral disturbance), psychotic disturbance, and mood disturbance. A review of the quarterly Minimum Data Set (MDS) for R10 revealed in section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 12, indicating she has moderate cognitive impairment. A review of the care plan revised on 8/22/2024 revealed R10 to be care planned for congestive heart failure, impaired cognitive function/dementia or impaired thought processes related to (r/t) Alzheimer's and dementia, and a communication problem r/t difficulty hearing, understanding/making herself understood at times r/t Alzheimer's and dementia, and a potential mood problem r/t her expressing fatigue, restlessness, feels bad about herself, and trouble concentrating r/t to dx (diagnosis) of Alzheimer's, and major depressive disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician's orders for R10 revealed an order for Ativan (lorazepam) 1 milligram (mg) oral tablet, to be administered one (1) tablet by mouth every four (4) hours as needed for agitation, with a start date of 10/26/2024 and an indefinite end date, documented that it was prescribed by the facility MD (doctor of medicine). A review of the physician's orders for Resident R10 revealed an order to be admitted to hospice for end-of-life care and comfort measures regarding congestive heart failure (CHF). During an interview on 10/30/2024 at 10:16 am with Registered Nurse (RN) VV and the Unit Manager revealed that she was aware that psychotropic medications prescribed as PRN must include a stop date within 14 days. RN VV stated that she typically verified that all psychotropic medications had an appropriate stop date and noted that physicians were generally diligent about including them, though she occasionally reminded them if necessary. RN VV further revealed that a potential negative outcome of not adhering to the 14-day stop date could be excessive sedation, which increased the risk of falls. During an interview on 10/30/2024 at 12:37 pm, the facility MD stated that a 15-day stop date was typically set for PRN psychotropic medications, after which the MD or a nurse practitioner would evaluate the resident. The MD noted that the stop date was usually included in the medication orders. The MD further explained that R10 had been in the facility for some time and frequently experienced outbursts, using PRN medication as needed. The MD indicated that a potential negative outcome of not having a stop date would be paradoxical agitation, as the medication could continue to be administered without proper oversight. The MD also stated that a stop date would be added to the medication order and the facility would be informed. Upon reviewing R10's EHR, the MD clarified that R10 was on hospice care, and the hospice team prescribed the medication. During an interview on 10/30/2024 at 3:20 pm with the RN Area Director from Hospice, they confirmed that Ativan was prescribed by their physician. The RN Area Director stated that she was unaware of the requirement for a 14-day stop date for PRN psychotropic medications. During an interview on 10/31/2024 at 10:51 am with the Director of Nursing (DON) confirmed that PRN psychotropic medications should have a 14-day stop date. When asked about the incorrect doctor being listed as the prescribing physician for the medication, the DON explained that, since the Hospice doctor's name is not in their EHR system, they only have one doctor name, which is why the facility's MD name was added. The DON further stated that they would look into adding the Hospice doctor's name to their system. The DON also noted that a potential negative outcome of not having a stop date would be excessive sedation and increased sleep. During an interview on 10/31/2024 at 10:56 am, the Administrator confirmed that all psychotropic medications should have a 14-day stop date. The Administrator emphasized that it was his expectation that the facility policy was followed, including the requirement for a 14-day stop date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50170 Based on observation, staff interviews, and review of the facility's policy titled, Food Service Director, the facility failed to maintain sanitary practices in the kitchen in regard to food handling and hair coverings. The deficient practice had the potential to affect 101 of 103 residents receiving an oral diet from the kitchen. Findings include: Review of the facility's policy titled Food Service Director revealed under Procedure: 6. Food is prepared in a manner that prevents food borne illness. Staff follow proper sanitation and food handling practices. Food is served as soon as possible after it has been prepared, and at the proper safe temperature. Observation on 10/29/2024 at 9:30 am revealed [NAME] NN without a beard net in the kitchen food preparation area. Observation on 10/29/2024 at 9:35 am revealed a fan blowing debris that was accumulated on the fan blades and wire cage towards the food preparation area. Observation on 10/29/2024 at 9:40 am in the dry storage room revealed an unsealed bag of instant food thickener. The bag was left open in the box with the top of the box open as well. The Dietary Manager (DM) was observed tying the bag back up and closing the box. Observation of soy sauce left in the dry storage area with over half of the product used with a label reading, Refrigerate after opening. The DM was observed throwing the product away. Interview on 10/29/2024 at 9:50 am with the DM revealed staff should always have on hair nets at all times as long as they are in the kitchen. She mentioned that they are currently out of beard nets, and she has ordered some and are waiting for them to arrive. However, in the meantime, staff can wear a mask. She also mentioned that the fan should not be blowing towards the food prep area.