STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185087	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Rivers Nursing and Rehabilitation Center	2420 West Third Street Owensboro, KY 42301

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on observation, interview, and record review, the facility failed to ensure the Resident Council's right to have their group meeting without staff present was honored and promoted for seven (7) of seven (7) residents reviewed for Resident Council resident rights out of a total sample of 25 residents, Resident (R)6, R12, R21, R38, R54, R56, and R63. This failure violated the residents' right to autonomy and to be able to bring up concerns without staff present. The findings include: R6, R12, R21, R38, R54 (Resident Council President), R56, and R63 attended the Group Interview conducted by the Surveyor on 07/25/2024 at 10:00 AM, in the Main Dining Room. Observation on 07/25/2024 at 10:00 AM, revealed two (2) activity staff and a dietary staff member sitting in the dining room for the meeting. When the Surveyor explained to the facility staff, the Group Interview meeting was closed to staff members of the facility unless a resident requested their presence, the staff exited the meeting. During the Group Interview, on 07/25/2024 at 10:06 AM, the group was asked if they regularly attended the Resident Council meetings. R38 stated she used to; however, she did not regularly attend anymore because staff ran the council meeting and not the residents. In continued interview, R38 stated in November 2023 or December 2023, she approached the Activity Director (AD) who ran the group, and explained to her the residents were supposed to be the ones who ran the group and not her. However, the AD informed R38, she was the one who had to conduct the meeting. R38 stated it was not a safe space if they had a concern about staff, but could not fully express it in fear of staff not keeping it confidential. All residents agreed with R38's concern. 1. Review of R6's undated Admission Face Sheet, located in the resident's Electronic Medical Record (EMR) under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R6's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/17/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated intact cognition. 2. Review of R12's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R12's quarterly MDS with an ARD of 05/30/2024, revealed the facility assessed the resident to have a BIMS score of 13 out of 15 which indicated intact cognition. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R21's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE]. Review of R21's quarterly MDS with an ARD of 05/07/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated intact cognition. 4. Review of R38's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R38's quarterly MDS with an ARD of 05/10/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated intact cognition. 5. Review of R54's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R54's quarterly MDS with an ARD of 05/17/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated intact cognition. 6. Review of R56's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE]. Review of R56's quarterly MDS with an ARD of 06/04/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated intact cognition. 7. Review of R63's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R63's quarterly MDS with an ARD of 06/07/2024, revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated intact cognition. During an interview, on 07/25/2024 at 10:54 AM, the AD stated she had been in her position since December 2023. When asked if residents could have the Resident Council meeting without her or other staff present, the AD stated she had been told she was required to attend the Resident Council meetings. The AD did not remember who told her she was required to attend the meetings. The AD further stated she did remember R38 telling her the meetings were to be run by the residents and not the staff and the residents did not want staff to attend. However, the AD stated she was not aware residents could hold the meetings without staff present. During an interview, on 07/26/2024 at 5:34 PM, the Administrator stated it was his expectation the facility would follow the regulatory requirement to allow residents privacy during the resident council group.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on interview, record review, and review of facility policy, the facility failed to issue the resident or their representative a written notification of transfer when the resident was transferred to the hospital for five (5) of five (5) sampled residents reviewed for emergency transfers out of a total sample of 25 residents, Resident (R)29, R36, R48, R73, and R199. The facility did not have a system in place for sending written notification of transfer to residents or their representatives. This created the potential for the resident and/or their representative to have incomplete information related to the reason for transfer, location of transfer and/or how to appeal the transfer, if desired. The findings include: Review of the facility's policy titled, Admission, Discharge, and Transfer Standard of Practice, dated 10/2020, revealed the purpose of the policy is to ensure the process of admission, discharge, and transfer meets regulatory requirements. Discharge/Transfer: . 2. Before the facility transfers or discharges a resident, the facility shall a) Notify the resident and resident representative to include the reason in a language and manner they understand .c) Notice of transfer or discharge will be made with at least 30 days notice for a safe transition; or as soon as practicable when .iii. An immediate transfer or discharge is required due to urgent medical needs. Further review of the policy, revealed it failed to address the requirement to provide written notice to the resident and the resident's representative(s) regarding transfer. 1. Review of R29's undated Admission Face Sheet located in the resident's Electronic Medical Record (EMR) under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Review of R29's EMR Progress Notes, located under the Progress Notes tab, revealed the Nurse's Status Note, dated 06/12/2024, stated new orders were received to send the resident to the hospital emergency room (ER) to evaluate and treat. The Assistant Director of Nursing (ADON) and Power of Attorney (POA) were notified. Further review of R29's EMR, revealed there was no documented evidence of a written transfer notice sent to the resident/resident representative regarding the hospital transfer on 06/12/2024. 2. Review of R36's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE] with diagnoses which included bipolar disorder, COPD, and chronic respiratory failure. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R36's Nurse's Progress Note, dated 03/08/2024 and located in the resident's EMR under the Progress Notes tab, revealed, At 1500 [3:00 PM] Resident was found on floor left side of bed face down . resident had just been in bed she had been very restless and anxious unable to redirect .resident assessed no injury noted no c/o [complaints of] or s/s [signs/ symptoms] of pain. Resident assisted back into bed per staff resident refused to let nurse get vitals and obtain full set of neuros .resident taking off O2 [oxygen] wont [sic] leave it on ripping out her hair very anxious and restless .call placed to [Medical Director] gave orders to send out to ER for eval [evaluation]. Call placed to EMS [Emergency Medical Services]. EMS arrived and took the resident out of facility at 1530 [3:30 PM]. Further review of R36's EMR, revealed there was no documented evidence of a written transfer notice sent to the resident/resident representative regarding the hospital transfer on 03/08/2024. Review of R36's Nurse's Progress Note, dated 04/03/2024 and located in the resident's EMR under the Progress Notes tab, revealed, Resident arrived [readmitted] at facility by stretcher per EMS and taken to her room . Review of R36's discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/2024 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview, on 07/24/2024 at 12:05 PM, R36 was questioned related to what kind of paperwork she received during her most recent transfer to the hospital. R36 stated she did not remember the facility giving her any written paperwork. 3. Review of R48's undated Admission Face Sheet, located in the EMR under the Face Sheet tab, revealed the facility admitted the resident on 01/18/2024 and readmitted the resident on 06/03/2024, with diagnoses which included polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body) and chronic kidney disease. Review of R48's EMR Progress Notes, located under the Progress Notes tab, revealed the Nurse's Status Note, dated 05/30/2024, stated, Resident being transported non-emergent via EMS [Emergency Medical Service] to the hospital at this time; r/t [related to] x-ray report of likely fracture to femoral head. Resident left facility at 11:15 AM. Direct admit to [room number]. All parties aware . Further review of R48's EMR, revealed there was no documented evidence of a written transfer notice sent to the resident/resident representative regarding the hospital transfer on 05/30/2024. During an interview, on 07/23/2024 at 1:50 PM, Family member (F) 48 stated, I did not receive anything in writing from the facility about her transfer to the hospital. 4. Review of R73's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the resident was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included unspecified dementia and type II diabetes mellitus with hyperglycemia. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R73's Nurse's Progress Note, dated 06/14/2024, located in the resident's EMR under the Progress Notes tab, revealed, Resident noted with gradual decline so far this shift. Refuses to keep NC [nasal cannula] in place, O2 [oxygen] sat [saturation] declines to 75-84% [percent] on RA [room air]. Staff attempt to replace NC without success. Phoned [Medical Director] to make aware and received order for 40 mg [milligram] IM [intramuscular] Lasix [a diuretic medication]. BP [blood pressure] 100/48 so unable to administer Lasix safely. Attempted to notify [Medical Director] but on call hours had began [sic]. Phoned on call MD [medical doctor] .Order received to send resident to .ED [emergency department] for evaluation. EMS here at 12:10 [PM] to transport resident. Further review of 73's EMR, revealed there was no documented evidence of a written transfer notice sent to the resident/resident representative regarding the hospital transfer on 06/14/2024. Review of R73's readmission Nurse's Progress Note, dated 06/15/2024 and located in the resident's EMR under the Progress Notes tab, revealed Resident arrived to facility per EMS at 1500 [3:00 PM] transferred to bed per EMS and staff . During an interview, on 07/23/2024 at 12:41 PM, Family Member (F) 73 stated she had received bed hold notices and policies during R73's hospital transfers; however, she had never received anything in writing about the resident's transfer including appeal rights. 5. Review of R199's undated Admission Face Sheet located in the EMR under the Face Sheet tab, revealed the facility admitted the resident on 07/10/2024 and readmitted the resident on 07/22/2024, with diagnoses which included femur fracture and Chronic Obstructive Pulmonary Disease (COPD). Review of R199's EMR Progress Notes located under the Progress Notes tab, revealed the Nurse's Status Note, dated 07/19/2024, stated Resident ambulating from room to hallway and fell . As she attempted to ambulate around her w/c [wheelchair] she tripped on the left w/c leg/pedal . ROM [Range of Motion] severely limited, length disproportionate. MD [Medical Doctor] notified with new orders to send to ER [emergency room] to eval [evaluate] and treat. Emergency contact- Husband [name] notified at this time . Further review of R199's EMR, revealed there was no documented evidence of a written transfer notice sent to the resident/resident representative regarding the hospital transfer on 07/19/2024. During an interview, on 07/25/2024 at 1:15 PM, the Administrator stated, We do not provide written notification of transfers to the resident or their representative. 36898

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43050 Based on interview, record review, and review of facility policy, the facility failed to ensure medication was administered according to professional standards of practice for one of 25 sampled residents, Resident (R) 81. This failure placed R81 at risk for inappropriate behavior, confusion, and disorientation. The findings include: Review of the facility's policy titled, Medication Administration Standard of Practice, dated 10/2020, revealed Medications will be administered in a safe and timely manner, and as prescribed .Medications must be administered in accordance with the orders, including any required time frame .The individual administering the medication must sign the resident's MAR/TAR [Medication Administration Record/ Treatment Administration Record] after giving each medication, along with any additional prior or follow up requested information. Review of R81's undated Admission Record located in the resident's electronic medical record (EMR) under the Resident tab, revealed the facility admitted the resident on 01/26/2024 with diagnoses which included lung cancer under Hospice care. Review of R81's Telephone Physician's order, provided by the facility, revealed orders for Ativan Intensol [anti-anxiety medication] [two] 2 mg [milligram] per [one] 1 ml, [one] 1 ml [milliliter] by mouth every [six] 6 hours for anxiety and sleep. This telephone order was undated and untimed, had no physician's signature, and was not placed into the Electronic Medical Record (EMR) order system. Review of the Patient Controlled Substance Administration Record-Liquids form, revealed Registered Nurse (RN) 3 signed as receiving 30 ml of Ativan from pharmacy on 03/14/2024. A sticker from pharmacy was attached to the controlled substance record which revealed R81's name and Lorazepam 2 mg/ml, generic for Ativan. Give 0.5 ml (1MG) by mouth every [six] 6 hours as needed for up to 10 days. Kentucky Medication Aide (KMA)1 initialed the form to indicate a 1.0 ml dose of Ativan was administered to R81 on 03/14/2024 at 0000 [12:00 AM], leaving a balance of 29 ml. [Therefore, 2 mg was administered instead of the 1 mg that was to be administered according to the sticker on the controlled substance record.] Review of R81's Medication Administration Record (MAR), dated March 2024, located in the resident's EMR under the MAR/TAR [Treatment Administration Record] tab, revealed no record of the Ativan medication being administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R81's Progress Note, dated 03/14/2024 at 6:42 AM, located in the EMR under the Documentation tab and the Progress Note tab, revealed Resident received new order for PRN [as needed] Ativan Intensol with medication delivered from pharmacy last night. First dose administered as requested. Soon after administration, the resident became very confused and disoriented. Staff entered the room to find [R81] undressed and sitting on the edge of his bed. [R81] was making multiple sexually inappropriate comments toward all staff but could be verbally redirected. Resident soon calmed and rested the remainder of the shift. Spoke with pharmacy about the directions on the medication bottle. The physician wrote an order for [one] 1 ml every [six] 6 hours PRN; however, the bottle read 0.5 ml every [eight]8 hours PRN [as needed]. Clarification from physician this morning was to follow directions as filled on script for 0.5 ml every 8 hours PRN. Review of a second telephone order provided by the facility, revealed an order clarification dated 03/14/2024, at 7:15 AM, for Ativan Intensol [two] 2 mg/ml, 0.5 ml by mouth every [six] 6 hours as needed PRN. Registered Nurse (RN)3 signed the order. During an interview, on 07/26/2024 at 6:55 AM, RN3 stated, The KMA gave the medication to the resident. I called the physician to confirm the dosage and write the new order that the physician signed. The Surveyor attempted to interview KMA1 by phone; however, the KMA did not respond to the calls. During an interview, on 07/25/2024 at 3:30 PM, the Director of Nursing (DON) stated, The order lacks the date and time as it was written, who wrote the order, and if the order was a verbal order. This is an incomplete order, and the resident was given the wrong dose according to the pharmacy label on the narcotic count sheet. During an interview, on 07/25/2024 at 4:16 PM, the Medical Director stated, I do not write a paper medication order. All orders are in the EMR. I would never write an order for Ativan. During an interview, on 07/26/2024 at 3:34 PM, the Administrator stated, My expectation for the medication administration is that nursing follows the protocols for professional standards of practice.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation, interview, and record review, the facility staff failed to administer a tube feeding as ordered by the physician for one (1) of two (2) residents reviewed for tube feeding out of a total sample of of 25 residents, Resident (R) 51. This failure had the potential for unplanned weight loss. The findings include: Review of R51's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR), revealed R51 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral aneurysm, chronic obstructive pulmonary disease, respiratory failure with hypoxia, gastrostomy status, and tracheostomy status. Review of R51's Physician's Orders located under the Orders tab in the EMR, revealed an order, dated 06/05/2024, for Glucerna 1.5 calorie 1210 ml/day (milliliters per day) at 55 cc/hour (cubic centimeters per hour) by gastrostomy for 22 hours and to have a 50 cc/hour water flush for 20 hours per day. Review of R51's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2024, revealed the facility assessed the resident as having short term and long-term memory loss; and as never/rarely making decisions. R51 was also assessed as having a gastrostomy feeding tube. Review of R51's care plan, dated 06/30/2024 and located under the Care Plan tab of the EMR, revealed . there will be no significant weight changes and tolerate enteral feedings/flushes . with an intervention of . Enteral feedings & [and] flushes per [by] order . During an observation, on 07/26/2024 at 12:22 PM, R51's tube feeding pump was noted to be infusing Glucerna 1.5 calorie at 50 cc/hour. During an interview, on 07/26/2024 at 1:02 PM, Licensed Practical Nurse (LPN) 1 stated, I always come into work and check to make sure the feeding is infusing. But to be very honest, I don't always check to make sure the rate is correct, but I should. When asked if she checked the infusion rate this morning, LPN1 stated, I don't remember if I did. During an interview, on 07/26/2024 at 1:30 PM, the Director of Nursing (DON) confirmed the nurse should always check to make sure the enteral feeding pump was set to infuse the rate of the feeding as ordered by the physician.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to ensure pain assessments were completed prior to and after the administration of PRN (as needed) narcotic pain medications for one (1) of two (2)sampled residents reviewed for pain management out of 25 sampled residents, Resident (R)19. R19 was ordered and administered pain medication; however, there was no documented evidence pre or post pain assessments were completed to measure if the medication was effective to ensure the resident's pain was being managed. This failure placed the resident at risk for a decreased quality of life related to uncontrolled pain. The findings include: Review of the facility's policy titled, Pain Management Standard of Practice, dated 07/2020, revealed The facility works to ensure compliance with the regulatory intent of F697, that pain management is provided to residents consistent with professional standards of practice, the comprehensive care plan, and the resident's goals and preferences .5. Monitoring for effectiveness and/or adverse consequences . Review of R19's undated Admission Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab, revealed the resident was readmitted to the facility on [DATE] with diagnoses which included chronic pain syndrome and polyneuropathy. Review of R19's Pain care plan, initiated 02/19/2020 and located in the resident's EMR under the Care Plan tab, revealed the resident's Care Plan identified the following problems: Patient has chronic pain in neck and shoulders; Dx [diagnosis] chronic pain syndrome; Dx Polyneuropathy; Resident returned to facility from pain clinic . [Pain Clinic Physician's Name] has now turned over pain management to [Resident's Attending Physician's Name] .[Resident's Attending Physician's Name] sent script at this time. Resident aware and verbalizes understanding; [R19's Name] has chronic pain r/t [related to] impaired mobility, contractures, and dx of OA [Osteoarthritis]. R19 Care Plan goal stated, Will not experience unrelieved pain through next review. R19's Care Plan included interventions of: .Administer medications as ordered and observe for effectiveness and side effects .Notify physician of any unrelieved s/s [signs/ symptoms] of pain . Review of R19's significant change in status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/20/2024 and located in the MDS tab of the electronic medical record (EMR), revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating intact cognition. The facility further assessed R19 as being on a scheduled pain management regimen, receiving PRN (as needed) pain medications, and frequently having pain during the assessment period. Review of R19's Physician orders located in the resident's EMR under the List tab, revealed an order, dated 05/20/2024, for Hydromorphone [narcotic pain medication] 2 mg [milligram] by mouth every [six] 6 hours as needed . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R19's Medication Administration Record (MAR), dated July 2024, revealed the resident was being administered the hydromorphone 2 mg tablet medication PRN (as needed). Continued review of R19's MAR revealed no documented evidence the resident's pain was being assessed prior to the administration of the pain medication, nor was the resident's pain being assessed post administration of the pain medication to measure the effectiveness of the pain medication, as of 07/24/2024. During an interview, on 07/24/2024 at 11:51 AM, R19 stated she felt like the facility could do better about controlling her pain. When asked to elaborate, the resident stated once her pain medications took effect, then her pain was better. The resident stated she just received her pain medication with her noon medications, about 30 minutes ago, and she would now rate her pain as a seven (7) out of 10 with 10 being the worse pain possible. During a subsequent interview, on 07/24/2024 at 4:00 PM, R19 stated the nurse came and explained to her she could have her pain medication every six (6) hours if she needed it. R19 further stated she thought her pain medication was scheduled and she did not know she could ask for it after six (6) hours of receiving a dose of pain medication. During record review and interview, on 07/24/2024 at 3:35 PM, Licensed Practical Nurse (LPN) 4 reviewed R19's MAR, dated July 2024, and confirmed there was no documented evidence the resident's pain was being assessed prior to the administration of the PRN pain medication of hydromorphone, nor post administration of the PRN pain medication. LPN4 stated the resident's MAR did not contain a pre or post pain level, but should have. The LPN stated normally when a resident was ordered a PRN pain medication, the MAR would automatically populate a pre and post section to document the assessments. LPN4 further stated it was important to complete a pre and post pain assessment to ensure the resident's pain was being managed appropriately. During an interview, on 07/26/2024 at 5:16 PM, the Director of Nursing (DON) stated it was her expectation R19's pain would have been assessed before and after the administration of her PRN pain medication. The DON further stated this was important to ensure the medication was effective. During an interview with the Administrator, on 07/26/2024 at 5:18 PM, he was questioned regarding the need for pain assessments before and after administration of pain medication. He stated he was not clinical and deferred to the DON.

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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. 36898 Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for two (2) of six (6) residents reviewed for unnecessary medications out of a total of 25 sampled residents, Resident (R)79 and R11. This failure placed both residents at risk for side effects such as drowsiness and sedation. R79 was ordered Lorazepam (fast-acting antianxiety medication) with no stop date to reevaluate the medical necessity of the medication. Additionally, R11 was ordered and routinely administered Hydroxyzine HCl (an antihistamine medication) for itching; however, the medication was being used to control the resident's behavior. The findings include: 1. Review of R79's undated Admission Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab, revealed the facility admitted the resident on 05/31/2023 and most recently readmitted the resident on 02/12/2024, with diagnoses which included generalized anxiety disorder (GAD) and restless leg syndrome. Review of R79's Physician's orders located in the resident's EMR under the List tab, revealed an order, dated 03/22/2024, for Lorazepam (fast-acting antianxiety medication) Oral Concentrate two (2) MG/ML (milligram/milliliter), one (1) ml By Mouth Every four (4) hours as needed. The order did not have a stop date. Review of R79's Medication Regimen Review (MRR), dated 03/26/2024 and provided by the facility, revealed a pharmacy recommendation of Per CMS [Centers for Medicare and Medicaid Services], PRN psychotropic medications are limited to 14 days (no exceptions). If use is beyond 14 days, the rationale and an estimated duration of use must be documented. Please add an estimated duration of use to prn Lorazepam for CMS compliance. The Medical Director responded to the recommendation by marking Resident is comfort measures-90 day stop date. Review of R79's Physician's orders located in the resident's EMR under the List tab, revealed a current order dated 05/30/2024 for Lorazepam Oral Concentrate 2 MG/ML, 1.5 ml By Mouth Every four (4) hours as needed. The order did not have a stop date. This order also included for Comfort Measures Only . Review of R79's Medication Administration Record (MAR), dated July 2024 and located in the resident's EMR under the MAR/TAR [Treatment Administration Record] tab, revealed the resident was ordered and administered the PRN (as needed) Lorazepam for agitation. The MAR revealed the resident was administered the Lorazepam on 07/01/2024, 07/08/2024, and 07/09/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review, on 07/25/2024 at 3:16 PM, the Medical Director who was also R79's Attending Physician, reviewed the orders and confirmed there was no stop date on the PRN Lorazepam. The Medical Director stated R79 was on end-of-life comfort care, and she was not aware a stop date was needed for the medication since the resident was on comfort care. During an interview, on 07/26/2024 at 5:22 PM, the Director of Nursing (DON) stated it was her understanding that a stop date for a PRN antianxiety medication was needed for a resident on comfort care. 2. Review of R11's undated Admission Face Sheet, located in the resident's EMR under the Face Sheet tab, revealed the facility admitted the resident on 11/03/2016 and most recently readmitted the resident on 11/22/2022, with diagnoses which included bipolar disorder, cerebral palsy, and generalized anxiety disorder. Review of R11's Physician orders located in the resident's EMR under the List tab, revealed a current order, originally dated 10/04/2023, for Hydroxyzine HCl [an antihistamine medication with anticholinergic side effects] Oral tablet 25 mg, [one] 1 tablet via G-Tube [Gastric Tube] TID [three times a day] .for itching. Review of R11's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/17/2024 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. The assessment also revealed the resident had not engaged in any behaviors during the assessment period. Review of R11's MARs, dated October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, April 2024, May 2024, June 2024, and July 2024 and located in the resident's EMR under the MAR/TAR tab, revealed the hydroxyzine medication was initialed as administered three (3) times a day as ordered except for the following dates: 11/16/2023 (one dose), 12/05/2023 (one dose), 01/12/2024 (two doses), 01/19/2024 (one dose), 02/22/2024 (one dose) and 06/21/2024 (one dose). An observation and interview with R11 was conducted on 07/23/2024 at 2:52 PM, in the presence of Licensed Practical Nurse (LPN) 4. When R11 was questioned if he had ever had any problems with his body itching, he stated No. Due to the resident having expressive communication deficit, LPN4 confirmed R11's answer was, No. LPN4 stated R11 had never complained to her of any itching; however, the resident did engage in the behavior of scratching his legs. Further observation revealed R11 had dressings on both legs. During a subsequent interview, on 07/24/2024 at 9:19 AM, R11 was questioned if he had any itching episodes overnight, and the resident stated, No. R11 was observed to be lying in his bed watching tv. During an interview, on 07/24/2024 at 3:48 PM, Certified Nursing Assistant (CNA) 4 stated she was often assigned to R11 and was familiar with him. CNA4 stated R11 had never complained to her about itching, and she had never observed him scratching himself from body itching. CNA4 further stated R11 used to scratch his legs a lot; however, this was a behavior when his call light was not answered quick enough. The CNA stated the resident would also engage in behaviors of yelling or putting himself on the floor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 07/24/2024 at 3:51 PM, CNA5 stated R11 had never complained to her about itching and she had never observed him scratching his body. During an interview, on 07/25/2024 at 3:16 PM, the Medical Director stated hydroxyzine was normally ordered and administered for itching. However, the Medical Director stated she ordered the medication for R11 more for behaviors and less for itching. The Medical Director further stated when she put the electronic order in, the drop down only had two diagnoses for hydroxyzine, anxiety and itching. In continued interview the Medical Director further stated the resident had wounds to his legs from him scratching himself, which was a behavior, and this was during a bad period of acting out. She stated she should have only ordered the medication for 10 days and stopped it after that. During an interview, on 07/26/2024 at 5:27 PM, the Director of Nursing (DON) stated it was her expectation the Medical Director would have followed the regulatory requirement for the use of the hydroxyzine medication. During an interview, on 07/26/2024 at 5:53 PM, the Administrator stated it was his expectation the Medical Director would have followed the regulatory guidance when prescribing the hydroxyzine medication.

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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. 43050 Based on observation, interview, and review of facility policies, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. These failures had the potential to affect all 95 residents in the facility who consumed food from the kitchen. The findings include: Review of the facility's policy titled, Food Storage: Cold Foods, dated 02/2023, revealed All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA [Food and Drug Administration] Food Code .All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Review of the facility's policy titled, Environment, dated 09/2017, revealed All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition .The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces .All food contact surfaces will be cleaned and sanitized after each use. On 07/23/2024, the following observations in the kitchen were identified and verified by the Dietary Manager (DM) and the District Manager. 1. Observation at 8:43 AM, revealed the freezer contained one (1) bag of hamburgers, (1) bag of cookie dough and one (1) bag of dinner rolls that were not sealed. 2. Observation at 9:00 AM, revealed the sanitizer was not dispensing sanitizer from the Eco Lab dispenser; therefore, the sanitizing part of the three (3) pan sink, and red sanitizing buckets had no sanitizer in them. The Surveyor asked the Dietary Manager to test the sink and the red bucket for sanitizer. No sanitizer registered with the test strips. The DM then added the sanitizer to the sink by hand and mixed it with water and the sanitizer registered. 3. Observation at 11:00 AM, revealed 60 plastic drinking cups and coffee mugs to be used for lunch were not allowed to air dry and were wet on the inside. They were stored stacked in a plastic container beside the tray line to be used for lunch. During this observation, the Dietary Manager asked dietary staff to rewash the cups. 4. Observation at 11:00 AM, revealed there were five (5) plastic cups that had a dried milky like substance and what appeared to be dried food particles on the inside of the cups that were to be used for lunch. The plastic cups were stacked in the dish washing room. During this observation, the Dietary Manager asked dietary staff to rewash the cups. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Observation at 11:00 AM, revealed there were six (6) dirty plates with what appeared to be dried food particles in the plate warmer that were ready to be used for lunch. They were stacked in the plate warmer beside the tray line. During this observation, the Dietary Manager asked dietary staff to rewash the plates. 6. Observation at 11:00 AM, revealed the dirty dishes and dishwasher were in the same room with clean dishes. When the dirty dishes and trays came through a window, a dietary staff member sprayed them before sending the dishes through to the dishwasher. The dirty spray from the dirty dishes was contaminating the clean cups and dishes which were on a rack in the same room. 7. Observation at 11:00 AM, revealed the 32 kitchen trays the residents used to serve the residents their meals had plastic pieces missing from the corners and edges. Interview with the Dietary Manager during the observation revealed new trays had been ordered. During an interview on 07/26/2024 at 3:26 PM, the District Manager stated, It is my expectation for the kitchen to be fully functional, sanitary, and timely. During an interview on 07/26/2024 at 3:21 PM, the Administrator stated, It is my expectation for the kitchen to follow policies and standards.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 28306 Based on observation, interview, record review, and review of facility policy, the facility failed to establish and maintain 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. The facility failed to follow infection control guidelines and facility policy during wound care dressing changes for three (3) of three (3) residents reviewed for wound care out of a total sample of 25 residents, Resident (R) 84, R19, and R81. The findings include: Review of the facility's policy titled, Skin Care Standard of Practice, dated 07/2020, revealed, .A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing . Review of the facility's undated Clean Wound Dressing Change competency for the nursing staff, revealed . Remove old dressing .Discard soiled dressing and gloves in plastic bag. Wash hands. [NAME] [put on] gloves .Pour sterile solution over gauze/cotton swabs using a basin or pouring over plastic bag. Cleanse wound using gauze/swabs from center outward in spiral motion with gentle pressure .Note on dressing: date, time dressing changed, and initials . 1. Review of R84's undated Face Sheet located in the resident's electronic medical record (EMR), under the Face Sheet tab, revealed the facility readmitted the resident on 05/07/2024 with diagnoses of stage IV pressure ulcers to the right and left buttocks. Review of R84's Care Plan located under the Care Plan tab of the EMR, dated 03/21/2024, revealed a Goal stating .open areas will heal without worsening or complications . Interventions put into place included: Foley catheter to assist in wound healing; Mattress - pressure reduction; Provide gentle support when turning/positioning/transferring, and Provide pressure ulcer care as ordered. Review of R84's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/06/2024, revealed the facility assessed the resident as having two (2) stage IV pressure ulcers that were facility acquired. Review of the Physician Orders located in the resident's EMR under the List tab, revealed an order, dated 07/25/2024 to: .Cleanse area to Right Buttocks with wound cleanser and pat dry. Pack wound with Iodoform Packing Strip and cover with border gauze daily . Review of the Physician Orders located in the resident's EMR under the List tab revealed an order dated, 07/25/2024 to: .Cleanse area to the Left Buttock with wound cleanser and pat dry. Mix collagen powder with Medi honey and apply to wound. Cover with border gauze daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation, on 07/26/2024 at 9:15 AM, with Licensed Practical Nurse (LPN) 2, the following failures were noted: 1) The scissors were cleaned with an alcohol prep pads prior to cutting the Iodoform packing strip gauze; 2) The over bed table was not cleaned prior to laying the barrier down on top of it; 3) LPN2 removed the resident's right buttock dressing, then while exposed the resident was turned to the other side. She then removed the left buttock dressing; 4) LPN2 removed her dirty gloves, then without performing hand hygiene, she applied clean gloves; 5) LPN2 cleaned the left buttock wound with a 4 x 4, then folded the 4 x 4 over and cleaned the wound again using the same 4 x 4; and 6) LPN2 sprayed the wound cleanser directly into the left buttock wound prior to cleaning the wound, and then applied Medi honey into the left buttock wound using a gloved finger. During an interview on 07/26/2024 at 5:55 PM, LPN2 stated, I only know to clean my scissors with the alcohol preps before using them on a dressing change. I realized I did not clean the over bed table with a bleach wipe when I laid the barrier down. When I was performing the wound care, I remembered that I needed to dress one wound then go to the other one, but that was after I started and had already removed the dressings on both areas. I did not realize that I had used my gloved finger to apply the ointment into the left buttock wound until we started talking about it just now. I should have used a Q-Tip, and I should have sprayed the wound cleanser to the 4 x 4 instead of spraying it directly into the wound. 2. Review of R19's undated Face Sheet located under the Face Sheet tab in the EMR revealed the facility readmitted the resident on 05/17/2024 with diagnoses including an unstageable pressure ulcer to the right calf and a stage II pressure ulcer to the right heel. Review of R19's Care Plan located under the Care Plan tab of the EMR, dated 05/08/2024, revealed a Goal stating .skin impairments will show signs of healing . Interventions included: Assist with turning/positioning; Provide diet/fluids as ordered; Provide pressure redistribution cushion to chair; Pressure redistributing mattress to bed to promote skin integrity; and Provide treatments as ordered. Review of R19's significant change MDS with an ARD of 05/20/2024, revealed the facility assessed the resident as having an unstageable pressure ulcer to the right calf and a stage II pressure ulcer to the right heel which were present on admission to the facility. Review of the Physician Orders located in the EMR under the List tab, revealed an order, dated 07/25/2024, to .Cleanse area to right calf with wound cleanser and pat dry. Moisten collagen sheet with normal saline and cut to size of the wound bed. Apply collagen sheet to wound bed. Moisten calcium alginate sheet with normal saline and cut to size of wound bed. Apply calcium alginate to wound bed over collagen. Apply superabsorbent dressing and cover with ABD [abdominal gauze] pad. Wrap with Kerlix from just below the knee to ankle daily. Review of the Physician Orders located in the EMR under the List tab, revealed an order, dated 07/25/2024, to .cleanse wound to Right heel with wound cleanser and pat dry. Apply Medi honey and cover with border gauze daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation, on 07/26/2024 at 9:45 AM, with Registered Nurse (RN) 1, the following failures were noted: 1) The over bed table was not cleaned prior to placing the barrier on the table; 2) The privacy curtain was touching the clean barrier on the over bed table where dressing supplies were located; 3) The bottle of wound cleanser was stored in the bedside table and was placed on the clean barrier without wiping it with a disinfectant wipe prior to wound care; 4) RN1 obtained Medi honey ointment from the original tube by using a Q-Tip and applied the ointment by spreading it to the outer edges of the wound first, then into the center of the wound on the right heel; 5) RN1 cleaned the wound to the right calf, then with the same soiled gloves, applied clean dressings as ordered with clean dressing supplies; 6) RN1 cleaned the wound to the right calf by wiping the 4 x 4 the length of the wound and did not use a circular motion; 7) RN1's dirty gloves touched the privacy curtain prior to removing them after the dressing change to the right calf; 8) The clean dressings were applied to the right heel and to the right calf with no dates documented on the dressings; and 9) RN1 took the dirty scissors back to the Medication Storage room in the rehab unit where clean supplies were kept. RN1 washed the scissors with soap and water, dried them, and placed the scissors back into the wound care cart. During an interview, on 07/26/2024 at 5:45 PM, RN1 stated, I know right off, I should have cleaned the over bed table with a wipe prior to starting. I sat the wound cleanser on the clean barrier, and I should not have. I realized when I was getting the Medi Honey out of the container that I should have placed it in a medicine cup and not brought the container into the resident's room, and I should have changed my gloves between cleaning and redressing the wound. I forgot to date the dressings that I had applied. When asked if RN1 should have taken the dirty scissors into the medication storage room where the clean dressing supplies were kept, RN1 replied, No. When asked if she should have used the disinfectant wipes to clean the scissors instead of using soap and water, RN1 replied, Yes I should have used the wipes. 3. Review of R81's undated Face Sheet located under the Face Sheet tab in the EMR revealed the facility admitted the resident on 01/26/2024 with diagnoses including an unstageable pressure ulcer of the right heel, diabetes, and peripheral vascular disease. Review of R81's quarterly MDS with an ARD of 05/03/2024, revealed the facility assessed the resident as having a stage IV pressure ulcer to the right heel which was facility acquired. Review of R81's Care Plan located under the Care Plan tab of the EMR, dated 03/04/2024, revealed a Goal stating .wounds will shoe [sic] improvement/heal . Interventions included: Float heels off mattress as resident will allow; Pressure reduction mattress; Treatment as ordered; and Provide gentle support when turning/positioning/transferring. During an observation, on 07/26/2024 at 11:15 AM with RN2, the following failures were noted: 1) The over bed table was not cleaned with a disinfectant wipe prior to placing the barrier down; 2) RN2 cleaned the wound, then used a 4 x 4 to wipe the wound twice without using a different area of the 4 x 4 for each time the wound was wiped. During an interview, on 07/26/2024 at 5:40 PM, RN2 stated, I didn't clean the over bed table with a wipe before I placed the barrier down and I should have. I should have used a clean 4 x 4 each time I wiped the wound or used a different area of the 4 x 4 each time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 07/26/2024 at 6:10 PM, the Director of Nursing (DON)stated, The over bed tables should have been cleaned with a disinfectant wipe prior to placing the barrier down. The nurses should change gloves after a wound is cleaned and before applying the clean dressings. The dressings should be timed and dated when the clean dressing is applied. Scissors should be cleaned with a disinfectant wipe and not soap and water before and after each dressing change. The nurse's dirty gloves should not touch the privacy curtain because you have contaminated the curtain when you do that. If the nurse is dressing two wounds, they should be treated as two different wounds. Each being dressed before the nurse moves on to the next wound. The wound cleanser should be sprayed on a 4 x 4 and not directly into the wound. When the nurse cleans a wound, they should start in the center cleaning in a circular motion and working their way out to the edges of the wound. The nurse can discard the 4 x 4 each time the wound is cleaned, or they can use a different area of the 4 x 4 to clean the wound. The wound cleanser bottle should not be placed on the clean barrier. Any type of ointment should be placed in a medicine cup and the tube or container should not be taken in the resident's room. This should be applied with a clean Q-Tip.