STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195321	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Opelousas	7941 I-49 South Service Road Opelousas, LA 70570

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 41419 Based on record review and interviews, the facility failed to provide individual financial record to the resident through quarterly statements and/or upon request for 1 (#5) of 1 (#5) residents investigated for personal funds. The deficiency had the potential to affect a census of 107. Findings: On 08/28/2024, a review of the provider's policy titled General Resident Trust Fund Policies with a last reviewed date of 08/2021, read in part, quarterly statements shall be provided to all residents, or their resident representative within 30 days after the end of the quarter. Resident #5 was admitted to facility on 09/22/2023 with diagnoses that included Chronic Kidney Disease, Type 2 Diabetes Mellitus, Retention of Urine, and Paraplegia. Review of Resident #5's MDS (Minimum Data Set) dated 06/04/2024, revealed a BIMS (Brief Interview of Mental Status) score of 15, indicating the resident was cognitively intact. On 08/26/2024 at 12:35 p.m., an interview was conducted with Resident #5 who stated that he had not received quarterly statements informing him of his account balance. On 08/28/2024 at 4:20 p.m., an interview was conducted with S14AA (Administrative Assistant) who stated Resident #5 had received his quarterly financial statements. S14AA was not able to provide evidence that Resident #5 was provided with quarterly financial statements. On 08/28/2024 at 4:30 p.m., an interview was conducted with S15AM (Accounts Manager) who stated the facility did not have any documented evidence that Resident #5 had received his quarterly financial statements. She further stated that she and S14AA were not trained to document when the resident's or the resident's representative financial statements were issued their quarterly financial statements. On 08/28/2024 at 5:05 p.m., a follow up interview was conducted with Resident #5, who was shown a copy of his financial statement for 03/30/2024 through 06/28/2024. The resident stated he had never seen a statement like what he was shown. He stated that he had requested a copy of his statement from S14AA, and she had not provided the information to him.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** 49784 Based on observations and interview, the facility failed to ensure the cleanliness of a wheelchair for 1 (#33) out of 2 (#33 and #105) residents investigated for a safe, clean, comfortable and homelike environment, out of a total sample size of 39 residents. Findings: A review of the facility's policy titled Equipment and Supplies with a last reviewed date of 01/2024 read in part, 7. Resident Care equipment will be cleaned and decontaminated after use and will be prepared for reuse by the same or another resident. Equipment will be cleaned and decontaminated according to manufacturer's recommendation. Resident #33 was admitted to the facility on [DATE] with diagnoses which included Unspecified Dementia. On 08/26/24 at 10:00 a.m., Resident #33 was observed sitting in her room in her wheelchair. Resident #33's wheelchair was observed with a large amount of yellow food-like residue on the seat, the foot petal bars, and the wheels of the wheelchair. On 08/26/2024 at 11:00 a.m., an interview and observation was conducted with S29LPN (Licensed Practical Nurse) of Resident #33's wheelchair. S29LPN confirmed that the wheelchair was dirty and should be cleaned. S29LPN confirmed that that Resident #33's wheelchair should not have been in that condition.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354 Based on record review and interview, the facility failed to ensure that a MDS (Minimum Data Set) assessment was completed and submitted to CMS (Center for Medicare And Medicaid Services) in a timely manner, after a resident was discharged for 1 (#82) of 1 (#82) resident investigated for Resident Assessment out of a final sample of 39 residents. The deficient practice had the potential to affect 107 residents. Findings: Review of Resident #82's medical record revealed an admitted [DATE], and a discharge date of [DATE]. Further review of Resident #82's medical record revealed no documented evidence that a discharge assessment was opened, completed and/or transmitted since he was discharged . On 08/28/2024 at 4:39 p.m., an interview was conducted with S18MDS (Minimal Data Set). who confirmed Resident #82 was discharged home on 05/06/2024. She also confirmed the discharge assessment had not been opened, completed, or transmitted in greater than 120 days and should have been.

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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** 39319 Based on record review and interview, the facility failed to ensure the resident's Minimum Data Set (MDS) was completed accurately for 1 (#56) out of 39 sampled residents. Findings: Review of Resident #56's clinical medical record revealed she was admitted to the facility on [DATE]. Her current diagnoses include, but where no limited to, Cerebral Infarction, Hemiplegia affecting right dominant side, Chronic Obstructive Pulmonary Disease and Muscle Weakness. Review of Resident #56's Significant Change MDS dated [DATE] revealed under Section P-Restraints, the resident was coded for the use of restraints. Review of the resident's active physician order as of 08/01/2024 revealed no order for restraints. On 08/26/2024 at 8:30 a.m., an interview and review of the residents MDS dated [DATE] was conducted with S9LPN/MDS (Licensed Practice/Minimum Data Set. She confirmed that she incorrectly coded the use of the bed rails as a restraint on the resident's MDS.

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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** 47251 Based on record reviews, interviews and observations, the facility failed to develop and/or implement a resident centered comprehensive plan of care for 3 (#36, #76 and #105) out of 39 sampled residents as evidenced by failing to: 1. implement Resident #36's plan of care to apply bilateral heel protectors while in bed; 2 develop a plan of care for Resident #76 that addressed his significant weight loss; and 3. develop a plan of care to address Resident #105's Urinary Catheter and her diagnosis of Urinary Tract Infection. Findings: 1. Resident #36 Review of Resident #36's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Pressure Ulcer of Sacral Region Stage 4, Rash and other Nonspecific Skin Eruption, Unspecified, and Severe Protein-Calorie Malnutrition. Review of Resident #36's care plan revealed a problem onset on 04/02/2021 which read in part .Resident is at risk for further skin breakdown due to decline in mobility. This problem included a goal for the resident to have no new skin breakdown through next review date 10/16/2024, and an intervention for bilateral heel protectors while in bed. Review of Resident #36's August 2024 EMAR (Electronic Medical Record) revealed bilateral heel protectors while in bed signed by nurses as completed on 08/27/2024 at 6 a.m., 2 p.m. and 10 p.m., and on 08/28/2024 at 6 a.m. On 08/27/2024 at 9:40 a.m., Resident #36 was observed lying in bed with no bilateral heel protectors on. On 08/28/2024 at 08:33 a.m., an observation of Resident #36 and an interview was conducted with S21CNA (Certified Nursing Assistant). S21CNA confirmed that Resident #36 did not have bilateral heel protectors and stated that she should have been wearing the heel protectors. She further stated that she had worked with Resident #36 on 08/27/2024 from 6 a.m. to 2 p.m. and that the resident did not use the heel protectors and should have. S21CNA confirmed that she was aware that Resident #36 should have used bilateral heel protectors while in bed. On 08/28/2024 at 8:42 a.m., an interview, record review and observation of Resident #36 was conducted with S19LPN (Licensed Practical Nurse). S19LPN confirmed that Resident #36 was care planned for bilateral heel protectors, and was not wearing bilateral heel protectors and should have. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #76 Review of Resident #76's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Vascular Dementia, Anxiety Disorder and Unspecified Sequelae of Cerebral Infarction. Review of Resident #76's Significant Change MDS (Minimal Data Set) with an ARD (Assessment Reference Date) of 06/12/2024 revealed a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, and was not on a prescribed weight loss regimen. Review of Resident #76's resident centered comprehensive care plan revealed no evidence that his weight loss had been addressed. On 08/28/2024 at 2:31 p.m., an interview and record review was conducted with S17AN (Assessment Nurse). She confirmed that Resident #76 had a significant weight loss that was coded on his Significant Change MDS with an ARD of 06/12/2024. S17AN also confirmed that she had not addressed Resident #76's weight loss on his comprehensive care plan and stated she should have. 39319 3. Resident #105 Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included in part, Urinary Tract Infection, Type 2 Diabetes Mellitus, Unspecified Hydronephrosis and Essential Hypertension. Review of the resident's 5-day PPS (Prospective Payment System) MDS (Minimum Data Set) assessment dated [DATE] revealed under Section H-Bladder and Bowel, the resident was coded for having an indwelling catheter. Further review revealed under Section I: Active Diagnosis, the resident was coded for have a UTI (urinary tract infection) in the last 30 days. Review of the resident's care plan revealed no evidence that the resident's urinary catheter and UTI was addressed in the care plan. On 08/28/2024 at 3:30 p.m., an interview conducted with S17ANAssessement Nurse). She confirmed that according to Resident 105's electronic clinical record, the resident did have a urinary catheter and had a UTI. Then, a review of the resident's care plan was conducted with S17AN. She confirmed the resident's urinary catheter and UTI was not addressed in her care plan and should have been.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41419 Based on record review and interview, the facility failed to facilitate the resident's and if applicable, the resident representatives' participation in the care planning process for 1 (#5) of 2 (#5, and #76) residents investigated for care planning out of a total sample of 39 residents. Findings: Review of Resident #5's medical records revealed he was admitted to the facility on [DATE] and he was his own representative. Review of the resident's MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating he was cognitively intact. Review of S16SS (Social Services) notes dated 11/02/2023 read in part .the residents daughter was having phone trouble, but left her P.O Box address so that she could also be contacted by the facility via mail. On 08/26/2024 at 12:35 p.m., an interview was conducted with Resident #5, in which he stated that he had not been invited to attend any care plan meetings. On 08/27/2024 at 4:15 p.m., an interview and review of a copy of the mailing envelope was conducted with S16SS. She stated she mailed the care plan meeting invitation to Resident #5's daughter. The copy of the mailing envelope was addressed to Resident #5 with his home address, but on closer observation the address was different from the one provided to the facility by the resident's daughter on 11/02/2023. On 08/27/2024 at 4:20 p.m., further review of Resident #5's hard chart revealed no evidence that quarterly care plan meetings had been conducted after 01/04/2024. On 08/27/2024 at 4:30 p.m., an interview was conducted with S16SS, who failed to provide documented evidence that care plan meetings were being conducted quarterly, or that the resident's daughter had been invited to the quarterly meetings.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20777 Based on observation, record review and interviews the facility failed to provide oral care for 1 (#64) of 4 (#44, #56, #64, #91) residents reviewed for ADL's (Activities of Daily Living) from a sample of 39 Residents. Findings: Record review revealed Resident #64 was admitted to the facility on [DATE] and had a BIM (Brief Mental Exam) of 10. She had a diagnosis of Muscle weakness and required extensive assistance with all ADL's. Record review of Resident #64's Care Plan revealed the C.N.A.'s were to assist Resident #64 with maintaining good oral hygiene daily. On 08/26/24 at 12:48 p.m., an observation revealed Resident #64 had a white milky substance between her upper and lower teeth. At this time Resident #64 stated she has been in the facility going on 2 months and during this time the staff have not provided her with oral care in the morning. On 08/27/24 9:12 a.m., another observation revealed Resident #64 had a white milky substance between her upper and lower teeth. At this time Resident #64 stated no one had assisted her to brush her teeth after breakfast. On 08/27/24 at 9:13 a.m., an interview with S7LPN revealed Resident #64 required staff to assist her with brushing her teeth. At this time S7LPN observed Resident #64's oral Cavity and stated the residents teeth were nasty and needed to be cleaned. On 8/27/24 at 9:29 a.m., an interview with S24 C.N.A. revealed Resident #64 was a total assist and needed the C.N.A.s to brush her teeth daily. On 08/027/24 at 12:48 p.m., an interview with S17 AN (Assessment Nurse) revealed Resident #64 required extensive assistance with ADL's (Activities of Daily Living) and it was the C.N.A.'s responsible to provide oral hygiene for the resident daily.

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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** 47251 Based on observations, interviews, and record reviews, the facility failed to provide respiratory care consistent with professional standards of practice for 2 (Resident #31 and #54) of 3 (Resident #31, Resident #54 and Resident #359) investigated for respiratory care by failing to properly store: 1. Resident #31's nebulizer mask, and 2. Resident #54's BiPAP (Bilevel Positive Airway Pressure) mask Findings: 1. Resident #31 Review of Resident #31's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included, but not limited to, Chronic Obstructive Pulmonary Disease with Exacerbation, Chronic Systolic Heart Failure and Shortness of Breath. Review of Resident #31's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 07/30/2024 revealed a BIMS (Brief Interview for Mental Status) of 14, indicating he was cognitively intact. Review of Resident #31current physician's orders read in part, Pulmicort 0.5 mg/2ml (milligram/milliliter) respule - Give 2 ml per neb (nebulizer) tx (treatment) twice a day. Brovana 15 mcg/2ml (microgram/milliliter) solution - Give 2 ml per neb tx twice a day. On 08/26/2024 at 09:15 a.m., during an interview with Resident #31, an observation was made of Resident #31's nebulizer mask on his bedside table open to air. Resident #31 stated that the nurses administered his nebulizer treatments and that the mask was never stored in a bag. On 08/26/2024 at 10:15 a.m., a second observation was made of Resident #31's mask on his bedside table open to air. On 08/26/2024 at 12:45 p.m., an interview and observation was with conducted with S19LPN (Licensed Practical Nurse). S19LPN confirmed that Resident #31's nebulizer mask was on his bedside table opened to air and not stored properly. 46169 2. Resident #54 A review of Resident #54's electronic health record revealed she admitted to the facility on [DATE] with diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disorder, Pleural Effusion, Pneumonia, and Acute Pulmonary Edema. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #54's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date of 06/25/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating her cognition was intact. Section O: Special Treatments, Procedures and Programs was checked for Non-invasive Mechanical Ventilator, Bi-level Positive Airway Pressure (BiPAP). A review of Resident #54's August 2024 physician's orders that included but were not limited to, BiPap at bedtime (settings 12/6), Cleanse BiPap mask with soap and water daily after use. On 08/26/2024 at 10:48 a.m., an observation was conducted in Resident #54's room. Resident #54's BiPap mask was observed on the night stand, not in use, open to air and not stored in a bag. Further observation of the BiPap mask revealed spots of a dried dark red substance inside the mask. On 08/26/2024 at 10:55 a.m., an observation and interview was conducted with S25LPN (Licensed Practical Nurse). S25LPN confirmed Resident #54's BiPap mask had spots of dried dark red substance inside the mask was open to air and not stored appropriately. She confirmed the mask should have been cleaned and placed in a bag.

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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** 20777 Based on interviews, and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice and the comprehensive person-centered care plan for 1 (#64) of 3 (#11, #64, and #69) residents sampled for pain. The facility failed to ensure Resident #64 who displayed verbal pain received the ordered interventions to alleviate pain. Findings: Record review revealed Resident #64 was admitted to the facility on [DATE]. She had diagnosis that included but were not limited to, Pain in Leg, Intervertebral Disc Degeneration in her Lumbar Region, Scoliosis, Angina Pectoris, Weakness, and Type 2 Diabetes Mellitus. Her BIMS (Brief Interview for Mental Status) was 10 (Moderate Cognitive Status). Record review of Resident #64's care plan read in part, Resident is at risk for pain. Administer meds as ordered. Notify MD (Medical Doctor) of any unrelieved pain. Record review of Resident #64's physician orders read in part, Tylenol 325 milligram tablet take one by mouth once every 6 hours as needed for pain. On 08/26/2024 at 12:53 p.m., an interview was conducted with Resident #64. She stated she had back pain that comes from her sciatic nerve and the nurse gives her Tylenol for the pain. On 08/27/2024 at 8:39 a.m., during a skin assessment with S22TN (Treatment Nurse) Resident #64 complained of back pain that was an 8 to 9 on the pain scale with 10 being the worst. She asked S22TN if she could ask her nurse to bring her some Tylenol for the pain. Resident #64 then stated she had asked the nurse for Tylenol for pain last night (08/26/2024) and the nurse did not bring her Tylenol. On 08/28/2024 at 11:02 a.m., S22TN was asked if she had notified S7LPN (Licensed Practical Nurse) on 08/27/2024 that Resident #64 had complained of pain. She stated she did notify S7LPN regarding the residents pain. Record review of Resident #64's MAR (Medication Administration Record) for August 2024 read in part, Tylenol 325 milligram take one tablet by mouth once every 6 hours as needed for pain. On 8/13/2024 at 12:22 p.m., the resident was administered her Tylenol for a pain level of 5. Resident #64 did not receive any Tylenol on 08/26/2024, or 08/27/2024. Record review of Resident #64's nurses notes dated 08/27/2024 revealed there was no notation that S22TN had notified S7LPN of the resident's pain or that S7LPN had administered Resident #64 Tylenol for pain. On 08/28/2024 at 11:17 a.m., an interview with S7LPN revealed she did not administer Resident #64 any Tylenol for pain on 8/27/2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/2024 at 3:00 p.m., an interview with S2DON (Director of Nursing) revealed that the nursing staff should manage the residents pain as ordered by the physician.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46169 Based on observation, record reviews, and interviews, the facility failed to ensure nursing staff demonstrated competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 2 (# 61, #78) residents out of 39 sampled residents. The facility failed to ensure staff demonstrated competency for: 1. safe injection practices when S27LPN used Resident #61's used multi-dose insulin pen designed for single patient use to administer insulin to Resident #6; and 2. correct application of Resident #78's bed bolsters by CNAs (certified nursing assistants). The facility had a census of 107 residents. Findings: 1. On 08/28/2024, a review of the facility's policy titled Injections with a last reviewed date of 01/2024 read in part, Purpose: To administer medication via injection. Procedure: 2. Verify the physician's order, comparing the medication label to the order verify the following: a. Right medication, b. Right dosage, c. Right route, d. Right time, e. Right resident. Resident #61was admitted to the facility on [DATE] with diagnoses which included but were not limited to, Type 2 Diabetes Mellitus. A review of Resident #61's electronic health record (EHR) revealed a physician's order dated 12/21/2023 that read, Novolog Flexpen syringe (multi-dose insulin pen device designed for single patient use), Accu-check (blood glucose monitor) AC (before meals) and HS (hour of sleep) to SS (sliding scale). A review of Resident #61's August 2024 Electronic Medication Administration Record (EMAR) revealed on 08/27/2024 at 11:00 a.m., she was administered 4 units of Novolog Flexpen by S27LPN. A review of Resident #6's EHR revealed a diagnosis of Type 2 Diabetes Mellitus. Further review revealed a physician's order dated 04/20/2017 that read, Novolog Flexpen syringe, Accu-check AC and HS. (continued on next page)

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	195321	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Opelousas	7941 I-49 South Service Road Opelousas, LA 70570

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/2024 at 11:17 a.m., an observation was made of S27LPN during medication administration. S27LPN completed a blood glucose check on Resident #61 that read 163. S27LPN prepared 4 units of Novolog Flexpen according to the physician order. She stated the Novolog Flexpen was for Resident #61 and administered the injection. After S27LPN administered the injection, an observation of pharmacy label on the Novolog Flexpen revealed it was labeled with Resident #6's name. S27LPN confirmed the Novolog Flexpen was labeled with Resident #6's name and that it had been previously used to administer insulin to Resident #6. S27LPN confirmed she administered Resident #6's Novolog Flexpen to Resident #61. She stated she should have checked the label prior to administration and should not have administered Resident #6's insulin to Resident #61. S27LPN further stated, There were too many insulin pens that were all bunched up and I just grabbed a Novolog Flexpen. On 08/27/2024 at 11:32 a.m., an interview was conducted with S2DON. She confirmed insulin pens were not to be used on another resident. During the interview, S27LPN entered the S2DON's office and informed her that she had administered Resident #6's previously used insulin pen to Resident #61. S2DON stated S27LPN knew that she should have verified the resident's name on the label of the insulin pen. S2DON further stated she conducted an in-service on 08/06/2024 with the nurses, including S27LPN, regarding medication administration. 49784 2. Resident #78 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Hemiplegia following Cerebral Infarction with the Right Dominant Side Affected, and Unspecified Dementia. Review of the Resident #78's Care Plan revealed the following: Problem Onset 07/26/2022, In part: Falls, Resident is at Risk for Falls due to SP (Stroke Progression) CVA (Cardiovascular Accident) with right sided weakness Approaches, In part: 06/26/2024 Bed Bolsters; 8/19/2024 for fall on0 08/15/2024. Staff to ensure that bolsters are in proper position. Review of Nursing Note for Resident #78, on 8/20/2024 at 6:45 a.m., by S9LPN, revealed in part: CNA reported resident found on floor at 0120. Code green called. Upon entering room noted bed in lowest position, floor mats in place, one bed bolster in place noted other one wasn't secured correctly after further evaluation. Neuros started, increase supervision and tighten bed bolster correctly. On 08/27/24 at 12:48 p.m., and interview was conducted with S3ICP. S3ICP stated that she was responsible for investigating falls. She stated that Resident #78 had bolsters on both sides of the bed to assist with fall prevention. She stated that on 8/20/2024, a CNA had admitted she did not know how to apply the bolsters correctly, resulting in Resident 78#'s fall on 8/20/2024. She stated she did not remember who the CNA was that was involved in the fall on 8/20/2024. She stated S9LPN reported that she educated the CNA after the fall on 8/20/2024 on proper use of the bolsters. She stated that these findings were the result of her investigation. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 05:15 p.m., an interview and observation of Resident #78's bed bolster was conducted with S10CNA while the resident was in bed. S10CNA confirmed that left bed bolster was not clipped. She stated that she was not assigned to Resident #78 at that time, but stated she did care for her at times. She stated that she was familiar with using the bolsters but had never been educated on the proper use of them. On 08/28/24 at 01:42 p.m. an interview and observation was conducted with S11CNA. S11CNA stated she was assigned to Resident #78 at that time. She stated that she had never been educated on the proper use of the bolsters. On 08/28/24 at 1:50 p.m. an interview was conducted with S2DON (Director of Nursing). S2DON stated that she was unaware of any staff education on bolsters and that S12CNAS (Certified Nursing Assistant Supervisor) was responsible for keeping records of all CNA education. On 08/28/24 at 01:55 p.m. an interview was conducted with S12CNAS. S12CNAS stated that she believed some of the CNA's were in-serviced on the bolsters but not all of them. She further stated that she personally had not conduced any bolster in-services. She confirmed that the facility had no documentation of staff being educated on the use of the bolsters for Resident #78.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49784 Based on observation and interview, the facility failed to properly store drugs as evidenced by loose pills found in the bottom of medication cart drawers for 3 (Cart A, Cart B, and Cart C) of 3 medication carts checked for safe and secure storage. Findings: On 08/28/2024 a review of the facility's policy titled Medication Storage, with a last reviewed date of 01/2024, revealed in part, Policy Statement: There shall be storage areas provided that assure adequate space, equipment and security for medications within the facility, including .Medication rooms, refrigerators and medication/treatment carts shall be maintained in a clean and orderly manner per the facilities' policy and procedure. On 08/28/24 at 10:56 a.m., Cart A and Cart C were checked with S19LPN (Licensed Practical Nurse). Four loose pills were observed underneath the residents' medication blister packs of Cart A. These included: one white oblong tab (tablet), one white oval tab, one half of a green oval tab, and one pink and brown capsule. Eight pills were observed underneath residents' medication blister packs of Cart C. These included : two white round tabs, one orange round tab, one white rectangle tab, one yellow gel capsule, one pink round tab, one-half white round tab, and one half orange oval tab. On 08/28/24 at 11:53 a.m., Cart B was observed with S29LPN. One small green oval tab was observed underneath the residents' medication blister packs.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 44418 Based on observation, record reviews, and interviews, the facility failed to ensure that recipes were followed for residents who received pureed diets, by failing to follow a recipe for steamed rice. This deficiencies had the potential to effect 8 residents receiving a pureed diet. Findings: On 08/27/2024, a review of the facility's policy titled Preparation and service of pureed diets with a revision date of 05/18/2018, with no review date, read in part, Policy: Pureed diets are served when a modification in texture is needed because of lack teeth, chewing, and/or swallowing problems. Pureed foods are prepared in a consistency that is appropriate for each resident's ability to chew and shallow. 6. The pureed foods should be blended to the consistency that holds its shape such as mashed potatoes, unless otherwise specified in the diet order. Only the smallest amount of liquid possible should be used to puree the foods, since dilution will decrease the amount of calories, protein, vitamins and minerals the resident/patient will receive. A review the recipe for Steamed Rice puree revealed: Steamed rice for 15 serving: Steamed Rice - 11.25 cups 1. Prepare rice according to regular recipe. Milk Whole Bulk - 1 cup Soft Margarine bulk - 1/2 cup 2. Place food in processor, process until smooth by adding 1.5 TBSP milk and 2.5 tsp (teaspoon) of margarine per portion. On 08/26/2024 at 9:55 a.m., an observation was conducted of S8Cook preparing pureed steamed rice. S8Cook confirmed she was preparing the steamed rice for 15 serving. S8Cook placed 4 cups of steamed rice in the processor, then added one and a half (1 1/2) quarts of milk into the processor with the 4 cups of rice and began to blend the mixture. After blending the mixture, S8Cook opened the food processor and stated the steamed rice was too thin. S8Cook then placed two (2) TBSP of thickener into the mixture. On 08/26/2024 at 10:05 a.m., an interview was conducted with S5DM (Dietary Manager), she confirmed the recipe should have been be prepared for 15 servings. She stated per the recipe S8Cook should have used 11.25 cups of steamed rice, with 1 cup milk, and 1/2 cup of soft margarine bulk.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784 Based on record review and interview, the facility failed to coordinate care as evidenced by failing to obtain pertinent information from the contracted hospice agency for 1 (#99) out of 2 (#99, #46) residents investigated for hospice. Findings: A review of the facility's Assignment and Assumption Agreement with the contracted Hospice Agency dated [DATE] read in part: Preparation- Nursing Facility and Hospice each shall prepare and maintain complete, detailed clinical records for each patient receiving services under this Agreement in accordance with prudent record- keeping procedures, and as required by applicable federal and state laws and regulation on Medicare/Medicaid guidelines. Review of the Resident #99's electronic medical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Dementia, Pain, and Unspecified protein- calorie malnutrition. Review of the Resident #99's clinical record revealed a Hospice Certification that expired on [DATE] and the last Hospice Nurse Visit Note on record was dated [DATE]. On [DATE] at 11:39 a.m., an interview was conducted with S2DON (Director of Nursing). She stated that Resident #99 was currently receiving Hospice services. When asked about the Hospice certification and Hospice Nursing Visit Notes, she replied, We don't look at that, and referred surveyor to S28MRS (Medical Records Supervisor). On [DATE] at 11:46 a.m., an interview was conducted with S28MRS. S28MRS confirmed that the last Hospice Certification on record for Resident #99 was the Certification dated for [DATE] through [DATE]. S28MRS also confirmed that the last Hospice Nurse Visit Note for Resident #99 on record was dated [DATE].

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46169 Based on observation, interview and record review, the facility failed to maintain an effective infection control program in order to prevent the transmission of communicable diseases and infections as evidenced by failing to ensure: 1. a previously used insulin multi-dose pen that is designed for single patient use, was not used to administer insulin to another resident. 2. proper cleaning of glucometer between use 3. staff wore proper Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP) while performing high contact resident care activity. 4. proper use and storage of PPE for used on residents in contact isolation. This deficient practice resulted in an Immediate Jeopardy (IJ) on 08/27/2024 at 11:17 a.m. when S27LPN (Licensed Practical Nurse) used Resident #6's previously used insulin multi-dose pen, designed for single patient use, to administer insulin to Resident #61. This deficient practice placed 6 residents who receive insulin by multi-dose pens at risk for potential exposure to blood-borne pathogens. S1ADM (Administrator) and S2DON (Director of Nursing) were notified of the Immediate Jeopardy on 08/27/2024 at 5:25 p.m. The Immediate Jeopardy was removed on 8/28/2024 at 12:55 p.m., after it was verified through observations, interviews, and record reviews that the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. The facility had a census of 107 residents. Findings: 1. On 08/27/2024, a review of the facility's policy titled Injections with a last review date of 01/2024 read in part, Purpose: To administer medication via injection. Preparation .Verify the physician's order, comparing the medication label to the order verify the following: a. Right medication b. Right dosage c. Right route d. Right time (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	e. Right resident Review of FDA (United States Food and Drug Administration) Drug Safety Communications, Safety Announcement dated 02/25/2015 revealed the following in part: FDA requires label warnings to prohibit sharing of multi-dose diabetes pen devices among patients. Insulin pens and pens for other injectable diabetes medicines should never be shared among patients, even if the needle is changed. Sharing pens can result in the spread of serious infections from one patient to another. Pens must never be used for more than one patient because blood may be present in the pen after use. Sharing pens can lead to transmission of infections such as the human immunodeficiency virus (HIV) and hepatitis viruses. Pens should be clearly labeled with each patient's name or other identifying information. Verify the pen with the name of the patient and other patient identifiers to ensure the correct pen is used on the correct patient. Resident #61 admitted to the facility on [DATE] with diagnoses which included, but were not limited to Type 2 Diabetes Mellitus. A review of Resident #61's electronic health record (EHR) revealed a physician's order dated 12/21/2023 that read, Novolog (insulin) Flexpen syringe (single patient use), Accu-check (blood glucose monitor) AC (before meals) and HS (hour of sleep) to SS (sliding scale). A review of Resident #61's August 2024 Electronic Medication Administration Record (EMAR) revealed on 08/27/2024 at 11:00 a.m., she was administered 4 units of Novolog Flexpen by S27LPN. A review of Resident #6's EHR revealed a diagnosis of Type 2 Diabetes Mellitus. Further review revealed a physician's order dated 04/20/2017 that read, Novolog (insulin) Flexpen syringe (single patient use), Accu-check (blood glucose monitor) AC (before meals) and HS (hour of sleep). A review of Resident #6's August 2024 EMAR revealed she was administered Novolog Flexpen on 08/26/2024 at 4:00 p.m. and 8:00 p.m., also on 08/27/2024 at 6:00 a.m. and 11:00 a.m. On 08/27/2024 at 11:17 a.m., a observation was made of S27LPN during medication administration. S27LPN completed a blood glucose Accu-check on Resident #61 that read 163. S27LPN prepared 4 units of Novolog Flexpen according to the physician order. She stated the Novolog Flexpen was for Resident #61 and administered the injection. After S27LPN administered the injection, an observation of the Novolog Flexpen that was administered revealed a label which read Resident #6's name Novolog. S27LPN confirmed the Novolog Flexpen was labeled with Resident #6's name and that it was previously used to administer insulin to Resident #6. S27LPN confirmed she administered Resident #6's Novolog Flexpen to Resident #61. She stated she should have checked the label on the Novolog Flexpen prior to administration. S27LPN confirmed she should not have administered Resident #6's insulin to Resident #61. S27LPN further stated, There were too many insulin pens that were all bunched up and I just grabbed a Novolog Flexpen. On 08/27/2024 at 11:32 a.m., an interview was conducted with S2DON. She confirmed insulin pens are not to be used on another resident. During the interview, S27LPN entered the S2DON's office and informed her that she had administered Resident #6's previously used insulin pen to Resident #61. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/28/24 at 2:11 p.m., an interview was conducted with S3ICP. She confirmed that insulin flexpens are for single resident use only and are not to be shared due to the risk of blood-borne pathogen transmission and infections. 2. On 08/28/2024, a review of the policy titled Blood Glucose Quality Control with a last review date of 01/2024 read in part, Maintenance of Blood Glucose Monitoring Systems, Always clean the meter after each use. Gently wipe to clean and disinfect the surface of the meter with a disinfectant wipe per facility policy. On 08/27/2024 at 11:17 a.m., an observation was made of S27LPN (Licensed Practical Nurse) during medication administration. S27LPN completed a blood glucose check on Resident #61 and placed the uncleaned glucose monitor on the medication cart. After S27LPN administered Resident #61's insulin, she placed the uncleaned glucose monitor in the drawer. S27LPN confirmed she did not disinfect the blood glucose monitor after use. S27LPN stated that she only disinfects the monitor at the beginning and the end of the shift and did not disinfect the glucose monitor after use with each resident. On 08/27/2024 at 11:32 a.m., an interview was conducted with S2DON (Director of Nursing). She confirmed the blood glucose monitor should be disinfected after each use. On 08/28/24 at 2:11 p.m., an interview was conducted with S3ICP who confirmed blood glucose monitors are to be disinfected between all patient use and as needed when soiled. 41419 3. Review of the provider's policy and Ppocedure titled Enhanced Barrier Precautions, read in part Enhanced Barrier Precautions (EBP) involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .Hand hygiene is recommended before and after resident contact .As part of Standard Precautions, gown and gloves should be removed and hand hygiene performed when moving to work with another resident. Resident #44 was admitted to the facility on [DATE] with diagnosis that included contracture of left and right hand. On 07/11/2024, resident had underwent placement of a PEG (percutaneous endoscopic gastrostomy) tube (indwelling medical device). On 08/28/2024 at 2:35 p.m., an observation was conducted in the room of Resident #44, which revealed a sign on the door that the resident was on Enhanced Barrier Precautions (EBP). Further observation revealed S13CNA (Certified Nursing Assistant) entered the resident's room, and asked if she needed assistance. S13CNA was observed assisting the resident without gloves or an isolation gown to locate her call bell and repositioned it for her. Further observation revealed S13CNA moved and adjusted the resident's blanket on her bed to locate the resident's hat. S13CNA then rubbed the resident's leg as she spoke with her. S13CNA exited Resident #44's room without sanitizing her hands, and entered another resident's room, and was observed with the water pitcher in her hand. On 08/28/2024 at 2:37 p.m., an interview was conducted with S13CNA who confirmed that she should have had gloves on while she assisted Resident #44, and sanitized her hands before entering another resident's room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/28/2024 at 3:30 p.m., an interview was conducted with S3ICP (Infection Control Preventionist) who confirmed that S13CNA should have had gloves on while assisting Resident #44, and sanitized her hands before entering another resident's room. 20777 Record review of Resident #27's Care Plan read in part, Nutritional Status, PEG (Percutaneous Endoscopic Gastrostomy) Feeding and flush as ordered. Enhanced Barrier Precautions as Ordered. Record review of Resident #27's Physician Orders dated 04/16/2024 read in part, Enhanced Barrier Precautions: Gown and gloves to be worn during high contact resident care Activities (.Feeding Tube). On 08/27/2024 at 11:45 a.m., an observation of Resident #27's room door revealed a sign on the outside that read in part, STOP . Enhanced Barrier Precautions .Providers and Staff must .Wear gloves and gown for the following High-Contact Resident Care Activities .Device Care or used: Feeding tube. Surveyor knocked on the door and S30LPN (Licensed Practical Nurse) responded. On entering the room, S30LPN was observed flushing Resident #27's PEG tube with water. She was wearing gloves and not wearing a gown. S30LPN was asked if Resident #27 was on Enhanced Barrier Precautions and she stated Yes. When asked if she should be wearing a gown to flush the residents PEG tube, she stated she should be wearing a gown. On 08/27/2024 at 12:09 p.m., an interview was conducted with S3ICP (Infection Control Preventionist) who confirmed that Resident #27 was on Enhanced Barrier Precaution for her PEG tube. S3ICP stated that staff should wear gown and gloves when flushing or cleaning the resident's PEG tube. 49784 Resident #72 was admitted to the facility on [DATE] with diagnosis including Pressure ulcer of sacral region, stage IV. Review of Resident #72's Physician Orders, in part, revealed an order dated 07/9/2024 for Enhanced Barrier Precautions: Gown and gloves to be worn during high contact activities (Hygiene, Toileting, Chronic Wound care). Review of Resident #72's Care Plan revealed the following: -Problem Onset 07/9/2024, Resident has a Pressure Ulcer- Stage 4 Pressure Ulcer to Sacral Region -Approaches, In part: Enhanced Barrier Precautions Followed On 08/27/24 at 2:30 p.m., an observation of wound care for Resident #72 was made, and an interview was conducted with S23CNA (Certified Nursing Assistant). Resident #72 was noted to have a sign on her door reading in part: Enhanced Barrier Precautions, Stop, Wear gloves and a gown for the following high- contact resident care activities: Changing briefs, wound care. S23CNA was observed assisting during wound care, turning Resident #72 and changing her brief without wearing a gown. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/28/24 at 2:25 p.m., an interview was conducted with S3ICP (Infection Control Preventionist). S3ICP confirmed that S23CNA should have been wearing a gown while assisting with wound care and changing a brief for Resident #72. 44418 4. On 8/27/2024 at 9:30 a.m., an observation was made of S7LPN (Licensed Practical Nurse) entering Resident #75's room to administer medication. She was not wearing any PPE. The resident was on contact precautions for an infection with Extended-Spectrum-Beta-Lactamase (ESBL). An interview was conducted with S7LPN when she exited the resident's room. She confirmed the signage on the door indicating the need for Enhance Barrier Precautions (EBP) because the resident had a catheter. She then acknowledged the Contact isolation signage and stated she was unaware of the resident's contact isolation status. On 08/27/2024 at 9:43 a.m., a second observation was made of S7LPN entering Resident #38's room with no PPE on, looking behind and donning PPE after entering room. The resident's door had signage, acknowledging the resident was on droplet precautions due to a positive COVID-19 diagnosis and there were no PPE available at the outside entrance of the room. On 08/27/2024 at 9:50 a.m., an interview was conducted with S7LPN, in which she stated that S3ICP (Infection Control Preventionist) informed her the PPE was to be kept inside the room for EBP (Enhanced Barrier Precautions) and any type of isolation residents. On 08/27/2024 at 3:29 p.m., an interview was conducted with S3ICP who stated she had been instructed by a corporate nurse to keep PPE inside residents' rooms rather than outside at the point of entry. S3ICP confirmed Resident #75 was on contact isolation precautions for ESBL and Resident #38 was on droplet precautions for a positive COVID-19 diagnosis.