STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235155	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha T Berry McF	43533 Elizabeth Rd Mount Clemens, MI 48043

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49102 Based on interview and record review, the facility failed to ensure an update for a preadmission screening (PAS) and resident review (ARR) /Hospital Exempted Discharge for a Level II evaluation was completed for one resident (R187) of three residents reviewed for PASARR. Findings include: A review of the medical record revealed that R187 admitted into the facility on [DATE] with the following diagnoses of paranoid schizophrenia, post traumatic stress diorder and dissociative identity disorder. A review of the most recent Minimum Data Set assessment dated [DATE] was completed with a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. A review of the medical record revealed a Preadmission Screening with a hospital exemption dated on 9/18/24. There was no change in condition for hospital discharge within 30 days and the PASSAR had not been updated. There was no additional PASARR forms nor was a Level II screening requested due to R187 having mental illness diagnoses. On 01/28/2025 at 10:57 AM, an interview was conducted with Social Worker A regarding R187's level II screening not being completed. Social Worker A stated were not aware or who had been completing the 3877/3878 forms. On 01/29/2025 at 3:15 PM, an interview was conducted with the Director of Nursing (DON) regarding R187's level II screening not being completed. The DON said her expectation is the PASARR's and level II for each resident are completed accurately and timely per the policy. A review of a facility policy titled, RESIDENT ASSESSMENT- COORDINATION WITH PASARR PROGRAM revealed the following: 3. Individuals admitted under a Hospital Exempted Discharge and remains in the facility longer than the 30 days, must be screened by an authorized facility designee using the State's Level I screening process via Form DCH 3877 and the designee must refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination.

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 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** 49102 This citation pertains to Intakes MI00149363 and MI00149481. Based on observation, interview, and record review, the facility failed to implement a dental care plan for one resident (R110) out of one reviewed for comprehensive care plans. Findings include: On 01/27/25 at 10:00 AM R110 was observed laying in bed watching television. R110 was asked about dental care and stated they wanted teeth pulled at a dentist office, not the facility. A review of the medical record revealed R110 admitted into the facility on [DATE] with the following diagnoses, Dysphagia, Malnutrition, Adult Personality Disorders, and Adjusment Disorder. A review of the Minimum Data Set (MDS) assessment on 1/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 indicating moderately impaired cognition. Further review of of R110's medical record revealed dental consultions and issues with they're teeth. There was no comprehensive dental care plan with interventions noted in the medical record. On 01/29/2025 at 1:00 PM, an interview was conducted with Social Worker A regarding R110's dental care plan to which they responded, they had to go ask the other social worker and try to find care plan. At 2:15 PM, Social Worker A confrimed R110 did need a care plan and there was not one in the current medical record. On 01/29/2025 at 3:15 PM, an interview was conducted with the Director of Nursing (DON) regarding R110's dental care plan to which they replied their expectation is that care plans are completed accurately and timely for each resident. On 01/29/2025 at 2:09 PM, a request was made for the care plan policy and was not recieved by the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 Based on observation, interview, and record review, the facility failed to implement skin interventions and date skin care treatments, for one sampled resident (R153) of three reviewed for skin. Findings include: On 1/27/25 at 1:34 PM, R153 was observed in their room sitting in a wheelchair. R153 was asked about the care at the facility and mentioned they need a new bandage strip. R153's right elbow was observed with a brown bandage on it without a date and intial, R153's right upper thigh was observed with a brown bandage on it without a date, and R153's right leg was observed with a discolored area that was not covered. R153 explained the facility has not followed up and changed the bandages for a few days. On 1/29/25 at 9:42 AM, R153's skin on the left leg was observed with a large red area that had a large blister that was not covered. R153 reported it was not covered on 1/28/25 and the bandage on their right elbow needed to be replaced because it fell off. On 1/29/25 at 9:45 AM, Unit Manager A was asked to observe R153's skin. Unit Manager A reported R153 should have a bandage on the left leg and when skin treatments are completed the nurse is required to date and initial the bandage. On 1/29/25 at 10:51 AM, the Wound Nurse was asked the facility's expectations regarding wound treatments. The Wound Nurse reported, R153's treatments are completed on the night shift and the nurse should've dated and signed the bandage. A review of R153's medical record revealed two physian's orders: -Cleanse left anterior thigh with normal saline pat dry apply xeroform and cover with dry dressing every night shift and as needed for abrasion. Start 12/11/24 - end date: Indefinite. -Cleanse left and right legs with normal saline, pat dry, apply xeroform (gauze dressing) to open areas and cysts cover with ABD (dressing used to cover and protect wounds or incisions) and wrap lightly with kerlix. every night shift for wound care and as needed for wound care. Start 1/14/25 - end date: Indefinite. A review of R153's Treatment Administration Record (TAR) noted on 1/23/25, the order to cleanse left and right legs with normal saline, pat dry, apply xeroform to open areas and cysts cover with ABD and wrap lightly with kerlix every night shift for wound care, treatment box was without documentation the treatment was completed. Further review of R153's medical record revealed R153 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Acute Respiratory failure. A review of R153's quarterly Minimum Data Set (MDS) assessment, dated 10/22/14 noted R153 with an intact cognition and they required staff for activities of daily living. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R153's care plan revealed, I am at risk for impaired skin integrity r/t (related to) impaired mobility. Date Initiated: 01/13/2023. Goal: My skin will remain intact through the review date. Date Initiated: 01/13/2023. Interventions: Skin assessment weekly per protocol. Interventions to be implemented as needed based on findings. Date Initiated: 08/05/2024. Focus: I am at risk for complications r/t abrasion on L (left) thigh. Date Initiated: 12/13/2024. Goal: My skin abrasion will be healed by review date. Date Initiated: 12/13/2024. Interventions: Monitor/document location, size and treatment of skin abrasion. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (medical doctor). Date Initiated: 12/13/2024. On 1/29/25 at 3:07 PM, the Director of Nursing (DON) was asked the facility's expectation regarding documentation of treatments. The DON reported the treatments should be dated and initialed when completed. A review of the facility's policy titled Wound Care and Treatment Standard Operating Procedures dated 04/10/19 noted, PURPOSE The purpose of this Standard Operating Procedure is to ensure the clinical team treats resident wounds as part of the skin integrity program . 4. PROCEDURES This procedure is to be performed when it has been determined by the wound care nurse or physician or wound care specialist that a wound treatment is required and ordered: . 14.Dress wound. [NAME] dressing with initials, time, and date and apply to dressing .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview and record review, the facility failed to implement interventions to prevent the development of a deep tissue injury and subsequent stage 3 pressure ulcer (full-thickness skin loss) for one resident (R49), of three residents reviewed for pressure ulcers. Findings include: On 1/28/25 at 8:21 AM, R49 was observed in bed eating breakfast, heels flat on the bed. Attempts to interview the resident were to no avail as the resident was pleasantly confused. A review of R49's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Dementia, Muscle Weakness, and Psychotic Disorder. Further review of R49's medical record revealed they were significantly cognitively impaired, and was dependent for bed mobility per their care plan initiated on 12/13/23. Further review of R49's medical record revealed they sustained a fall on 8/6/24 resulting in a left hip fracture. Further review of R49's medical record revealed the following progress notes: 8/9/2024 18:41 (6:41pm) IDT (interdisciplinary team) Progress Note .Elder continues on IDT for falls. Elder had a fall on 8/6/24 at 18:15 (6:15pm) during a shower the elder had a witnessed fall. The elder was sent to the hospital and was noted to have a left hip fx (fracture). Elder had surgical repair and returned to facility WBAT L/LE (weight bearing as tolerated, left lower extremity) .Elder has hip precautions in place until surgical intervention is clarified with medical records and/or ortho (orthopedics) . 8/10/2024 17:59 (5:59pm) .Braden Scale for Predicting Pressure Ulcer Risk Evaluation Braden Evaluation: Sensory Perception: Slightly limited. Moisture: Rarely moist. Activity: Chairfast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Adequate. Friction and shear: Potential problem BRADEN Score: 16.0 (at risk) . 8/12/2024 11:28 (11:28am) Skin/Wound Note .Elder was readmitted to the facility on [DATE]. During the assessment, the following observations were made regarding the elder's skin: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 20 staples on the left hip - [NAME] and purple bruising on the left hip and left knee - [NAME] bruising on the right knee - Scattered skin tags and age spots on the upper and lower back - Dime-sized abrasion on the left buttock with slow blanching redness, no drainage, no pain, and no odor noted -bilateral feet, dry skin . 9/1/2024 08:03 (8:03am) General Nursing Note .CNA (certified nursing assistant) informed nurse of new skin condition observed on resident bilateral heels. Nurse observed discoloration of Left heel, soft tissue, nonbankable (non-blanchable), and black in color. Right heel exhibited redness slow (blood) return when blanching . 9/1/2024 14:39 (2:39pm) General Nursing Note .Writer alerted of skin concern to residents left heel. Writer assessed resident and noted the following; Darkened areas to left heel, irregular edges noted, surrounding skin normal in color. Heel cool to touch. Orders updated in [medical record]; interventions placed to aide in healing process. Wound care team to follow up. 10/2/2024 16:17 (4:17pm) Skin/Wound Note .Resident seen today by [nurse practitioner]. [R49] is being seen for left heel DTI (deep tissue injury) which is now a stage 3 pressure injury. Wound measures 1cm (centimeter) x 0.8cm x 0.2cm. Scant amount of serous drainage noted. Wound bed has 76-100% slough. The wound is stable. Peri-wound skin texture is normal . 10/4/2024 11:16 (11:16am) IDT Progress Note .[R49] is being brought to IDT for [their] left heel in house stage 3 pressure injury. This wound was previously dx (diagnosed) as DTI .[R49] is incontinent of bowel and bladder and needs two-person assistance with the gait belt for transfers. Staff assistance is required for bed mobility and turning . Further review of R49's medical record revealed upon the resident returning to the facility on [DATE] following their fracture, they did not have any new orders or care plan interventions to prevent the development of a pressure ulcer to the resident's heels due to their new limited mobility and at risk Braden Score. On 1/29/25 at 12:36 PM, Wound Care Nurse (WCN D) was interviewed regarding R49's pressure ulcer, and confirmed the resident sustained a fall in August and did have a reduction in mobility. WCN D explained interventions implemented once the DTI was identified, but was unable to provide an explanation as to why the resident didn't have interventions in place prior to the discovery of the DTI. On 1/29/25 02:23 PM, an interview was completed with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding R49's pressure ulcer on their left heel. They both acknowledged there were no interventions put into place prior to the development of the DTI, aside from a specialty mattress R49 was on prior to the fracture and all residents receive upon admission into the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Pressure Injury Prevention and Management policy revealed the following, 4. Interventions for Prevention and to Promote Healing a. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). b. Evidenced-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but not limited to: o Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); o Minimize exposure to moisture and keep skin clean, especially of fecal contamination; o Provide appropriate, pressure-redistributing, support surfaces; o Maintain or improve nutrition and hydration status, where feasible .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview and record review, the facility failed to implement adequate supervision, and effective fall interventions for one sampled resident (R117) of four residents reviewed for falls, resulting in multiple falls, and a hospitalization . Findings include: On 1/28/25 at 8:28 AM, R117 was observed in bed on their back, floor mats observed on both sides of the bed. Attempts to interview the resident was to no avail due to their cognition. A review of R117's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Dementia, Hypertension, and Muscle Weakness. Further review revealed the resident was severely cognitively impaired with a brief interview for mental status score of 3/15, had a language barrier, and was dependent on staff for all activities of daily living. Further review of the resident's medical record revealed the following progress notes related to unwitnessed falls: 9/17/2024 13:22 (1:22pm) Incident Note .Resident observed kneeling on [their] knees next to the bed on the floor mat by the activities lady. Resident was asked if [they were] okay, and the resident replied 'yes' 9/25/2024 16:45 (4:45pm) Incident Note .Observed on the floor in the dining room door entrance sitting sloughed (slouched) against the wall with wheelchair unlocked slightly near the resident . 9/30/2024 19:46 (7:46pm) General Nursing Note .Approx (approximately) 11:45 writer observed resident on footrests of w/c (wheelchair) leaning on left side of body. 10/9/2024 20:35 (8:35pm) General Nursing Note .Writer was informed by CENA (certified nursing assistant) elder was on the floor. Upon arrival elder was sitting on buttock, elder has floor mats which were in place. Elder was facing the hallway with feet pointed out towards the hallway pulling on [their] peg tube (feeding tube) . 11/1/2024 03:45 (3:45am) General Nursing Note .The resident was found on the floor in the hallway after an unwitnessed fall . 11/1/2024 16:20 (4:20pm) Incident Note .Writer received in report elder had an unwitnessed fall during night shift. during day shift while doing care CENA report elder in moderate pain, writer went into elder room elder shows s/o (signs of) pain guarding right hip, facial grimacing, limited ROM (range of motion) . 11/2/2024 07:30 (7:30am) General Nursing Note [Physician] was notified of elder Xray results. Right femoral neck fracture (upper leg bone), order was given to send elder to hospital . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/9/2025 10:44 (10:44am) Incident Note .Writer called into room by therapist because resident was halfway out of bed, upon arrival [R117] was on the floor sitting with [their] back against the bed, legs on the floor. Pt (patient) reported not knowing how [they] got on the floor . A review of R117's fall care plan revealed the following: Focus: I am at risk for falls r/t (related to) cognitive impairment, decreased mobility 2/2 right hip fracture and Parkinson's disease, and poor safety awareness. Date Initiated: 04/06/2023 Interventions: -Frequent rounding for safety Date Initiated: 04/27/2023 -I have a preference and safety need to not go to bed until after 8pm unless requested by elder Date Initiated: 10/10/2024 -I need constant reminders not to get up out of bed on my own. Date Initiated: 08/11/2023 -I need to be offered time to stretch my legs with assistance after sitting for long periods Date Initiated: 05/06/2024 -I will attempt to pick stuff up off the floor after I eat. Please clean the floor around me after I eat for safety Date Initiated: 06/24/2024 -I am incontinent, and I will attempt to self-transfer, please offer frequent checks for improved safety and comfort. Date Initiated: 01/16/2024 -If you see that I am restless please offer to get me up into my w/c and offer engaging activity Date Initiated: 08/14/2023 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Mediation review. Date Initiated: 01/09/2025 -Offer to assist me to bed for a nap after meals. Date Initiated: 04/14/2024 -Place me in common area anytime I'm awake to prevent me from falling. Date Initiated: 04/20/2023 Please bring me to the dining room prior to AM meal as tolerated Date Initiated: 01/23/2024 -Please get me up for activities daily Date Initiated: 11/05/2023 -Please have dycem in my W/C to help prevent me from sliding. Date Initiated: 04/24/2023 - Please have non-skid socks on while in bed, non-skid footwear out of bed Date Initiated: 04/24/2024 -Please toilet me before and after meals Date Initiated: 06/21/2024 -Reinforce need to call for assistance. Date Initiated: 04/07/2023 -Sometimes I enjoy breakfast in bed, when I am done eating, please offer to get me I will use bilateral floor mats at bedside for increased safety r/t impaired safety awareness -When I go down for bed, ensure I have a night snack. Date Initiated: 04/25/2024 - When in D/R (dining room) please have me seated at the table nearest the TV as I require closer (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision and have a preference for this table Date Initiated: 06/14/2024 -while placed in the common while awake I will be provided engaging activity to assist with maintaining safety. Date Initiated: 01/09/2025 On 1/29/25 at 11:51 AM, R117's falls and interventions following the falls were reviewed with the Risk Investigation Manager (RIM), and noted the following: -Regarding the 9/17/24 fall, the intervention was for the resident to be offered to get into their wheelchair and to an activity. -Regarding the 9/25/24 fall, the intervention was for a medication review however, prior to the review, the resident sustained another fall. The RIM acknowledged upon reviewing that fall, the resident did not have a dycem (non-slip material used for stabilization) in their wheelchair which had been care planned and was not being implemented. There were also no additional fall interventions following this fall. -Regarding the 10/9/24 fall, the intervention was for the resident to not go back to bed until 8pm unless requested by the elder. The RIM was asked about the resident's language barrier and explained the resident can shake their head for yes or no when answering questions. -Regarding the 10/31/24 fall, the resident was transferred to the hospital after sustaining a fracture however, upon the resident's return, the RIM acknowledged there were no interventions put into place. The RIM was asked about the process for assessing care planned interventions to ensure they are effective, and explained that falls are assessed for 72 hours following a fall in which the interdisciplinary team reviews the intervention and revise as needed. On 1/29/25 at 2:33 PM, an interview was completed with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding R117's falls and effective interventions not being in place. The DON acknowledged the interventions should be in place, and efforts have been put into place to decrease falls within the facility. A review of the facility's Falls-Clinical Protocol revealed the following, 6. A comprehensive care plan will be completed and will address risk factors identified during the fall risk assessment. Interventions will be implemented accordingly. 7. Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision is based on the individual residents assessed needs and identified hazards in the resident environment .

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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** 34851 Based on observation, interview, and record review, the facility failed to administer a pain patch for one sampled resident (R28) of one review for medication administration. Findings include: On 1/27/25 at 1:36 PM, R28 was asked about the care at the facility and stated, Yesterday they didn't give me my pain patch. R28 reported this happens often. A review of R28's medical record revealed, R28 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD). A review of R28's Minimum Data Set (MDS) assessment dated [DATE], noted R28 with an intact cognition and requires staff assistance to complete activities of daily living (ADLs). A review of the Medication Administration Record (MAR) for December 2024 revealed, Lidocaine Patch 4 % Apply to the painful area topically one time a day for Musculoskeletal pain. Apply to the affected areas/painful region -Start Date 06/17/2023. On December 20th the MAR was marked with a 9 indicated see nurses notes (for reason why not administered). A review of the cooresponding nursing noted did not document the reason the Lidocaine Patch medication was not administered. A review of R28's MAR for January 2025 revealed, Lidocaine Patch 4 % Apply to the painful area topically one time a day for Musculoskeletal pain. Apply to the affected areas/painful region. On January 24th the MAR was marked with a 9 indicated see nurses notes. A review of the cooresponding nursing noted did not document the reason the Lidocaine Patch medication was not administered. On 1/29/25 at 9:53 AM, Unit Manager A was asked about the number code 9 and the expectation for that code. Unit Manager A explained the nurse should put in a note to explain the reason whay a medicaiton is not given. Unit Manager A was asked if the Lidocain patch was a medication the facility had in their storage/backup box and later confirmed the facility does have that medication on hand and available for administration without waiting for the refill. A review of R28's care plan revealed, Focus: I am at risk for pain related to/resident has chronic pain related to Pressure points, Reduced mobility Date Initiated: 02/19/2021. Goal: If my pain exceeds what I deem as comfortable, my medication will be effective (reduce and/or relieve) within one hour of administration through next review date. Date Initiated: 02/19/2021. Interventions: Monitor my pain level for effectiveness of analgesic within one hour after administration. Date Initiated: 02/19/2021. Nursing and Therapy staff will confer with my physician if I display signs of pain or verbalizations of pain to determine if a medication adjustment is appropriate. Date Initiated: 02/19/2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235155	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha T Berry McF	43533 Elizabeth Rd Mount Clemens, MI 48043

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 3:08 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were asked about the medication not being available. The ADON explained the facility has the Lidocain patch on hand and is available for the residents. The DON explained there should be documentation when number code 9 is documented on the MAR. A review of the facility's policy titled, POLICY: MEDICATION - NOT READILY AVAILABLE dated 07/20/2024 noted, PURPOSE: There may be occurrences when resident medications are not readily available. The facility provides pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs/biologicals to meet the needs of each resident. This policy provides guidelines for licensed nursing staff if a medication(s) is not readily available. POLICY: It is the policy of [name of facility] that the facility accurately and safely provides and/or obtains pharmaceutical services, including the provision of routine and emergency medications/biologicals to enable continuity of care for current residents and an anticipated admission or transfer of resident from acute care or other institutional setting. PROCEDURE: 1. The facility will utilize a systematic approach to provide or obtained routine and/or emergency medications and biologicals in order to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time that a nurse is administering medications he/she will observe the current availability of medications and re-order medication in a timely manner. 4. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications. This would be through emergency medication boxes or Pyxis machine use, (if available). 5. In the event of a new order the facility is allowed 24-hours to begin a medication unless otherwise specified by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235155	A. Building B. Wing	01/29/2025

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview, and record review, the facility failed ensure a medication error rate not greater than 5%, for one resident (R181) out of four residents observed during medication pass, resulting in a medication error rate of 7.4%. Findings include: On 1/28/25 at 8:16 AM, Licensed Practical Nurse (LPN) B prepared medications for R181 which included Diltiazem (to treat high blood pressure) ER (extended release) and Methenamine Hippurate (to prevent urinary tract infections). After placing all medication tablets in a medication cup, LPN B stated oh the other nurse told me that they need to be crushed. LPN B explained there is a standing order that states medications can be crushed if needed. LPN B explained they had a reference book indicating medications could and could not be crushed. LPN B was then observed to reference the medication book and stated, I don't see them in here. LPN 'B then crushed all the medications, mixed them with pudding, and administered them to R181. LPN B was asked if they could call the pharmacy to ask if a medication should be crushed if it was not in the book. LPN B replied yes. A review of R181's medical record revealed they were admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia, Arthritis, and other specified disorders of bladder. Further record review revealed a Brief Interview for Mental Status score of 3, indicating significant cognitive impairment. Further review of R181's medical record revealed the following active medication orders: Methenamine Hippurate oral tablet 1 GM (gram). Give 1 tablet by mouth two times a day for UTI (urinary tract infection) prevention; Diltiazem HCL (hydrochloride) ER (extended release) oral tablet extended release 24-hour 240 mg (milligrams) Give 240mg by mouth one time a day for HTN (high blood pressure). On 1/28/25 at 3:23PM, Unit Manager (UM A) explained any extended-release medication should not be crushed, and that LPN B should have called the pharmacy if they were not sure. At this time a phone interview was conducted with Pharmacist C. Pharmacist C explained that Diltiazem ER is an extended-release medication and should not be crushed and explained that if Diltiazem ER is crushed the resident would get the whole dose of medication all at once instead of a continuous extended release which could cause their blood pressure to drop. Pharmacist C explained that Methenamine Hippurate should not be crushed because it has an enteric coating on it and if it were crushed it would irritate the resident's stomach and also since it is a antimicrobial the protein can break down in the stomach acid rendering the medication less effective. On 1/29/25 at 10:11 AM, the Director of Nursing (DON) explained if a medication is not listed in the reference book the nurse should call the pharmacy for clarification. A review of the facility's policy titled Crushed Medications revealed the following: Policy: It is the policy of (facility) to ensure medications administered crushed will be administered according to standards of practice for safety and accuracy in medication administration and free of significant medication errors. Procedure: 1. Medication shall be crushed according to physician orders .3. The pharmacist will review medications to be crushed for safety and stability .