STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325073	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Socorro Wellness & Rehabilitation	1203 Highway 60 West Socorro, NM 87801

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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 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** 41755 Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 2 (R #13 and R #25) of 7 (R #10, R #12, R #13, R #23, R #25, R #29 and R #32) residents reviewed for care plans. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: R #13 A. Record review of R #13's Admission Record, no date, revealed the following: 1. R #13 was admitted to the facility on [DATE]. 2. R #13 diagnoses: a. Fibromyalgia [disorder characterized by widespread musculoskeletal (involving both muscle and bones) pain accompanied by fatigue, sleep, memory and mood issues.] b. Cramp (sudden, unexpected tightening of one or more muscles that can be very painful) and spasm (sudden, twitching contractions that are not usually painful.) c. Unspecified osteoarthritis (inflammation of one or more joints that occur without a known cause resulting in pain, stiffness, and loss of mobility.) d. Pain unspecified (exact cause or type of pain cannot be determined.) e. Acute (sudden onset) and chronic (gradual and requires long-term treatment) respiratory failure (condition where there is not enough oxygen or too much carbon dioxide in your body.) f. Chronic obstructive pulmonary disease (COPD; group of progressive lung diseases that damage your airways and make it harder to breathe) g. Hypoxemia (low levels of oxygen in the blood that can affect body functions.) B. Record review of R #13's physician's orders revealed: (continued on next page)

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	1. Order date 01/04/24: Oxygen via nasal cannula (tubing used to deliver oxygen through the nose), 1 to 4 liters per minute (amount of oxygen delivered to resident) as needed for dyspnea (shortness of breath, the feeling that you cannot get enough air into your lungs), hypoxia (condition that occurs when the body tissues do not get sufficient oxygen supply), or acute angina (chest pain or discomfort that happens when the heart is not receiving enough oxygen-rich blood.) 2. Order date 01/04/24: Acetaminophen oral tablet (over the counter pain reliever used to treat mild to moderate pain). Give 650 mg (dosage of medication) every four hours as needed for pain. 3. Order date 07/24/24: Hydrocodone-acetaminophen oral tablet (opioid combination medicine used to relieve moderate to severe pain), 5-325 mg (strength of medication). Give one tablet by mouth every eight hours as needed for chronic pain. C. Record review of R #13's Care Plan, dated 01/05/24, revealed the following: 1. Focus (area of concern) R #13 had congestive heart failure (condition in which the heart does not pump blood as well as it should causing fluid buildup and shortness of breath) evidenced by supplemental oxygen. a. Intervention (actions taken by nursing staff to promote health and help residents heal and recover from illness and injury): Oxygen therapy continuous. 2. Focus date initiated 07/15/24: R #13 had acute and chronic pain/discomfort related to arthritis (condition with pain, swelling, and tenderness of one or more joints) and history of hip fracture. a. Intervention: Evaluate the effectiveness of pain interventions each shift. D. On 08/29/24 at 11:20 AM, during an interview with the DON, she confirmed the following: 1. R #13's care plan was not comprehensive due to the interventions section did not include the actions staff should take to ensure the resident was assessed and monitored for her use of oxygen and what signs and symptoms would indicate the need for additional intervention. 2. R #13's care plan was not comprehensive due to the intervention section did not include the actions staff should take to assist R #13 with her pain management. 3. The expectation was for nursing staff to provide more interventions/nursing actions to assist R #13 with her dependency on oxygen and to help her manage her pain. R #25 E. Record review of R #25's Admission Record, no date, revealed the following 1. R #25 was admitted to the facility on [DATE]. 2. R #25 diagnoses were as follows: (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Alzheimer's disease (a progressive disease that destroys memory and other important mental functions.) b. Unspecified dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities.) c. Neurocognitive disorder with Lewy bodies (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood.) d. Major depressive disorder (MDD;mood disorder that causes a persistent feeling of sadness and loss of interest.) e. Generalized anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure.) f. Other specified anxiety disorder (anxiety or phobias that don't meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive.) F. Record review of R #25's physician's orders, dated 08/05/24, revealed an order for Seroquel (antipsychotic medication that can treat schizophrenia, bipolar disorder, and depression), 200 mg twice a day for dementia. G. Record review of R #25's Care Plan, dated 02/10/23, revealed the following: 1. R #25 was on antipsychotic medication therapy. 2. R #25 will be free from any discomfort or adverse side effects from antipsychotic medication use through the review date. 3. R #25 will have positive results due to antipsychotic medication therapy (not a measurable objective.) 4. Staff did not document the diagnosis ro which R #25 took antipsychotic medication. 5. Staff did not document measurable objectives for R #25 taking antipsychotic medications. H. Record review of R #2's history and physical (H & P; comprehensive formal assessment by a healthcare provider that includes a thorough health history and physical examination), dated 05/24/24, revealed the following: 1. Bipolar disorder onset 04/06/24. 2. Depressive disorder onset 10/03/17. 3. A diagnosis of schizophrenia was not included in the history and physical form. I. On 08/28/24 at 3:24 PM, during an interview with the DON, she confirmed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. R #25 had an order for Seroquel for a diagnosis of dementia with irritability. 2. R #25's care plan did not include the reason for R #25's use of an antipsychotic medication. 3. R #25's care plan stated the resident would have positive results from the use of antipsychotic medication, but it did not document what specific outcomes would indicate that R #25 had positive results. 4. The expectation was for care plans to include the reason the resident took an antipsychotic medication and to have measurable objectives. 49313

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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. 47510 Based on interview and record review, the facility failed to ensure care plan revision occurred for 1 (R #30) of 4 (R #5, R #7, R #11, and R #30) residents reviewed for care plans, when they failed to update R #30's care plan to document that her lower dentures were lost. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: A. On 08/26/24 at 2:30 PM, during an interview, R #30's said she lost her bottom dentures. R #30 said she did not remember when she lost them. B. Record review of R #30's progress notes, dated 06/12/24, revealed R #30 wore full dentures. C. Record review of R #30's care plan, dated 06/21/24, did not document R #30's bottom dentures were missing. D. On 08/27/24 at 10:59 AM, during an interview, the Business Office Manager (BOM) confirmed R #30's bottom dentures are lost. The BOM said she was not sure when R #30's bottom dentures went missing, but it had been a while. E. On 08/30/24 at 12:15 PM, during an interview, the DON confirmed R #30's bottom dentures were missing. The DON stated the staff did not careplan R #30's lost dentures, but it should be on the care plan.

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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. 41755 Based on record review and interview, the facility failed to meet professional standards of practice for 1 (R #36) of 4 (R #10, R #22, R #29, and R #36) residents reviewed for medication administration, when staff did not administer R #36's blood pressure medication regardless of specific parameters (numerical or another measurable factor) from the medical provider. This deficient practice could likely lead to the resident having adverse (unwanted, harmful, or abnormal result) side effects or not receiving the desired therapeutic effect of the medication due to it not being administered. The findings are: A. Record review of R #36's Physician orders revealed: 1. Order date 08/29/23: amlodipine besylate (medication used to treat high blood pressure) tablet. Give 5 mg by mouth one time a day. Hold for systolic blood pressure (SBP; top number of blood pressure reading) less than 100. 2. Order date 08/30/23: lisinopril (medication used to treat high blood pressure) tablet. Give 10 mg by mouth one time a day. Hold for SBP less than 100. B. Record review of R #36's MAR for July 2024 revealed: 1. On 07/15/24, PM amlodipine, hold see nurse notes. 2. On 07/16/24, AM lisinopril, hold see nurse notes. C. Record review of R #36's MAR for August 2024 revealed: 1. On 08/12/24, AM lisinopril, hold see nurse notes. D. Record review of R #36's nurse progress notes revealed: 1. On 07/15/2024 at 4:15 PM, resident blood pressure was low. 2. On 07/16/2024, at 8:22 AM, resident blood pressure was low. 3. On 08/12/2024, at 8:51 AM, resident blood pressure was low. E. Record review of R #36's blood pressure readings revealed: 1. On 07/15/2024, 8:10 AM, blood pressure reading 107/62, staff did not document additional blood pressure readings for this date. 2. On 07/16/2024, at 4:18 PM, blood pressure reading 102/53, staff did not document additional blood pressure readings for this date. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 08/12/2024, at 4:03 PM, blood pressure reading 116/69, staff did not document additional blood pressure readings for this date. F. On 08/29/24 at 11:40 AM, during an interview, the DON confirmed the following: 1. Staff did not administer R #36's blood pressure medication according to the physicians' orders. 2. R #36's blood pressure medication order indicated the medication should only be held if the systolic blood pressure was less than 100. 3. There was not documentation of a systolic blood pressure less than 100 for R #36 on the dates staff did not administer the medication. 4. There were not blood pressure readings documented for R #36 at the time the medication was held. 5. The expectation was for staff to administer the medication unless it met the specific parameters indicated on R 36's physician's order, and they documented a blood pressure reading at the time they administered or held the medications.

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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** 49313 Based on record review and interview, the facility failed to ensure the resident's ability to perform activities of daily living (ADLs) was maintained or improved for 1 (R #12) of 2 (R #12 and R #25) residents reviewed for functional ability (the actual or potential capacity of an individual activity and tasks that can be normally expected). If the facility does not ensure that residents maintain or improve their functional abilities, then the residents are likely to experience a decrease in their ability to walk, transfer, and do other activities of daily living. The findings are: A. Record review of R #12's admission record, no date, revealed the following: 1. R #12 was admitted on [DATE]. 2. R #12 had the following diagnoses: a. Unspecified dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities.) b. Other displaced fracture of upper extremity. c. Polyosteoarthrities (any type of arthritis that involves five or more joints simultaneously.) d. History of falling. e. Alzheimer's disease (a progressive disease that destroys memory and other important mental functions.) f. Age related osteoporosis (a condition in which bones become weak and brittle.) B. Record review of R #12's quarterly MDS assessment, dated 04/17/24, revealed R #12 had the following functional abilities. 1. Eating- Supervision or touching assistance required (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the resident completes activity.) 2. Oral hygiene- Partial/moderate assistance (Helper does less than half the effort.) 3. Toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement)- Partial/moderate assistance. 4. Shower/bathe self- Partial/moderate assistance. 5. Upper body dressing- Partial/moderate assistance. 6. Lower body dressing- Partial/moderate assistance. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Putting on/taking off footwear- Partial/moderate assistance. 8. Personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene)- Partial/moderate assistance. 9. Roll left and right- Supervision or touching assistance. 10. Sit to lying- Supervision or touching assistance. 11. Lying to sitting on side of bed- Supervision or touching assistance. 12. Sit to stand- Supervision or touching assistance. 13. Chair/bed-to-chair transfer- Supervision or touching assistance. 14. Toilet transfer- Supervision or touching assistance. 15. Tub/shower transfer- Supervision or touching assistance. C. Record review of R #12's progress note, dated 06/14/24, revealed that R #12 fell and injured her arm. D. Record review of R #12's physician's orders, dated 06/16/24, revealed an order for X-rays of R #12's left hand, left wrist, and left forearm. E. Record review of R #12's x-ray report, dated 06/17/24, revealed resident had a fracture of her distal radius and ulna (bones in the lower part of the arm near the wrist) on her left arm. The fracture of the radius was nearly healed and the fracture of the ulna appeared recent. F. Record review of R #12's physician's orders, dated 06/18/24, revealed the following: 1. An order for R #12 to wear a splint to stabilize her fracture for six weeks. 2. The order for R #12 was completed on 07/30/24 (6 weeks after order). G. Record review of R #12's significant change MDS assessment, dated 06/21/24, revealed R #12 had the following functional abilities: 1. Eating- Partial/moderate assistance. 2. Oral hygiene- Substantial/maximal assistance (Helper does more than half the effort). 3. Toileting hygiene- Substantial/maximal assistance. 4. Shower/bathe self- Substantial/maximal assistance. 5. Upper body dressing- Substantial/maximal assistance. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Lower body dressing- Substantial/maximal assistance. 7. Putting on/taking off footwear- Substantial/maximal assistance. 8. Personal hygiene- Substantial/maximal assistance. 9. Roll left and right- Substantial/maximal assistance. 10. Sit to lying- Substantial/maximal assistance. 11. Lying to sitting on side of bed- Substantial/maximal assistance. 12. Sit to stand- Substantial/maximal assistance. 13. Chair/bed-to-chair transfer- Substantial/maximal assistance. 14. Toilet transfer- Substantial/maximal assistance. 15. Tub/shower transfer- Substantial/maximal assistance. H. Record review of R #12's care plan, dated 06/26/24, revealed R #12 had an activities of daily living (ADL) self-care deficit due to her fractured ulna. I. Record review of R #12's progress note, dated 07/21/24, revealed R #12 took off her splint after staff placed it and used her wrist normally. J. On 08/27/24 at 11:11 AM, during an interview with CNA #17, revealed the following: 1. R #12 required full assistance with ADL's. 2. R #12 was able to use her left arm normally. 3. He did not perform any restorative nursing (person-centered nursing care that is designed to improve or maintain the functional ability of residents, so they can achieve their highest level of well-being possible) with R #12. 4. He was unsure if R #12 received therapy; however, he see therapy take R #12 out of the secure unit for therapy. K. On 08/27/24 at 11:15 AM, during an interview with the MDS coordinator, revealed the following: 1. R #12 was functional with her left wrist for about three or four weeks. 2. Did not think anything was done to help R #12 return to her prior level of functioning. 3. The facility did not have a restorative nursing program. 4. He confirmed there was not an order for therapy to evaluate R #12 after her wrist healed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	L. On 08/28/24 at 03:09 PM, during an interview with the Certified Occupational Therapy Assistant, revealed the following: 1. Therapy did not evaluate R #12 after her fracture healed. 2. Staff should have referred R #12 for a follow-up to evaluate her functional abilities and her ability to participate with rehab, after her fracture healed. 3. The facility did not have a restorative nursing program. 4. R #12 would benefit from therapy or a restorative nursing program that was consistent.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 50497 Based on interview and record review, the facility failed to ensure a resident received restorative rehabilitation (focuses on maximizing an optimal level of functioning, enabling clients to regain/retain their independence following the debilitating effects of illness or injury) services as ordered by the physician for 2 (R #9 and #37) of 2 (R #9 and #37) residents reviewed for rehabilitation services. This deficient practice is likely to result in a decrease in residents functional mobility. The findings are: R #9 A. On 08/26/24 at 1:54 PM, during an interview with R #9, he stated he did not have any therapy services, but the nurses helped him move his arms and legs. B. Record review of R #9's physical (PT) and occupational therapy (OT) discharge summary, dated 07/16/24, revealed R #9 to discharge to same the skilled nursing facility (SNF) with right upper extremity (region of the body that includes the arm, forearm, wrist and hand) range of motion program [ROM; the movement potential of a joint from full extension to full flexion (bending), flexibility involving ligaments, tendons, muscles, bones and joints] in place. C. On 08/28/24 at 10:00 AM, during an interview with CNA #24, she stated the following: 1. She was trained on ROM. 2. When she worked with R #9, she did ROM with R #9 and allowed him to wash himself in the shower. 3. She let the nurse in charge know that she did ROM with the resident, but she was not sure if a note was documented or not. The CNA stated she was trained in school to do ROM. D. On 08/28/24 at 1:19 PM, during an interview with the DON, she stated the facility did not have a restorative program. E. On 08/28/24 01:23 PM, during an interview with the MDS Coordinator (MDSC), he stated the following: 1. The CNAs were allowed to do ROM with the residents, and they should document it. The MDSC stated there was not any documentation to show the CNAs did ROM exercises with the residents. The MDSC did not confirm if the CNAs were qualified to do ROM. 2. R #9 was discharged from therapy services, but the MDSC could not remember the date. R #37 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 08/26/24 at 2:19 PM, during an interview, R #37 stated the nurses helped him do exercises for his legs and arms. G. Record review of R #37's OT discharge summary, dated 03/25/24, R #37 was discharged to same the SNF with staff support. Instructions for bilateral upper extremity therapy exercises at bedside. H. On 08/28/24 at 10:00 AM, during an interview with CNA #24, she stated the following: 1. She received training on ROM. 2. When she worked with R #37, she did ROM with R #37 and allowed him to wash himself in the shower. 3. She let the nurse in charge know she did ROM with the resident, but she was not sure if a note was documented or not. The CNA stated she was trained in school to do ROM. I. On 08/28/24 at 1:19 PM, during an interview, the DON stated the facility did not have a restorative program. J. On 08/28/24 01:23 PM, during an interview with the MDS Coordinator (MDSC), he stated the following: 1. The CNAs were allowed to do ROM with the residents, and they should document it. The MDSC stated there was not any documentation to show the CNAs did ROM exercises with the residents. 2. R #37 did not have therapy at the moment. K. On 08/28/24 at 3:28 PM, during an interview with Certified Occupational Therapy Assistant (COTA), he stated he did not instruct the CNAs on how to do ROM exercises with the residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41755 Based on record review and interview, the facility failed to ensure pharmaceutical services (the direct, responsible provision of medication-related care) were met for 1 (R #10) of 4 (R #10, R #22, R #29, and R #36) residents reviewed for medications when they failed to provide routine medication for a resident. This deficient practice could likely lead to unresolved medical issues. The findings are: A. Record review of R #10's Physician orders revealed an order dated 06/27/24 for turmeric tablet (common spice often taken as a supplement which might reduce swelling). Give 1500 mg (strength of tablet) by mouth one time a day for supplement. B. Record review of R #10's MAR for August 2024 revealed staff documented the drug was not available from 08/14/24 through 08/28/24. C. On 08/29/24 at 11:16 AM, during an interview, CMA #1 stated the turmeric was not available, because R #10's family did not bring the turmeric to the facility. D. Record review of R #10's progress notes, no date, revealed staff did not document any communication with the pharmacy or with R #10's family regarding the turmeric. E. On 08/29/24 at 11:40 AM, during an interview, the DON confirmed there was not documentation in the record regarding R #10's turmeric. The DON stated she was unsure when R #10 would receive the turmeric or if her family was providing it to the facility. The DON confirmed the facility was responsible to ensure the resident received the turmeric supplement since it was a physician's order.

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	325073	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Socorro Wellness & Rehabilitation	1203 Highway 60 West Socorro, NM 87801

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers) unless the medication was necessary to treat a specific psychiatric diagnosis for 1 (R #25) of 5 (R #5, R #11, R #12, R #13, and R #25) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are: A. Record review of R #25's Admission Record, no date, revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 diagnoses as follows: a. Alzheimer's disease (a progressive disease that destroys memory and other important mental functions.) b. Unspecified dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities.) c. Neurocognitive disorder with Lewy bodies (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain. These deposits, called Lewy bodies, affect chemicals in the brain whose changes, in turn, can lead to problems with thinking, movement, behavior, and mood.) d. Major depressive disorder (MDD; a mood disorder that causes a persistent feeling of sadness and loss of interest.) e. Generalized anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure.) f. Other specified anxiety disorder (anxiety or phobias that do not meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive.) B. Record review of R #25's physician order, dated 08/05/24, the following was revealed: 1. An order for Seroquel (antipsychotic medication that can treat schizophrenia, bipolar disorder, and depression), 200 mg twice a day for dementia with irritability/agitation/aggression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A black box warning [the Food and Drug Administration's (FDA) most stringent label on medications, used to warn about severe side effects] for Seroquel stated, Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine (generic name for Seroquel) is not approved for the treatment of patients with dementia-related psychosis. C. On 08/28/24 at 3:24 PM, during an interview with the DON, she confirmed the following: 1. R #25 had an order for Seroquel for the diagnosis of dementia with irritability. 2. Dementia was not an appropriate diagnosis for the use of Seroquel. 3. The expectation was for residents who were prescribed an antipsychotic medication to have an appropriate diagnosis for that medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50497 Based on observation, and interview, the facility failed to store medications properly for all 17 residents in the East Unit (residents were identified by the Resident Matrix provided by the Administrator on 08/26/24), when they failed to ensure the medication cart did not contain loose medications. This deficient practice could likely result in residents obtaining or being administered medication not prescribed to them, receiving medications that are less effective, and may result in adverse side effects. The findings are: A. On 08/28/24 at 12:05 PM, during an observation of the medication cart assigned to the East Unit with rooms 101-114, one white round tablet was loose in the second drawer of the medication cart and located towards the back of the medication cards (cardboard and foil packaging prefilled with prescription medication.) B. On 08/28/24 at 12:06 PM, during an interview, CMA #24 confirmed white round tablet was loose and not in bubble pack or pill container.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 Based on observation and interview, the facility failed to store food and spices in accordance with professional standards of food service safety for all 43 residents (residents were identified on the resident census provided by the Administrator on [DATE]) who ate food prepared in the kitchen when they failed to: 1. Label open food in the refrigerator. 2. Properly seal open food in the refrigerator. 3. Ensure spices were labeled with open dates. 4. Remove expired seasoning. These deficient practices could likely lead to foodborne illnesses. The findings are: A. On [DATE] at 11:54 AM, during an observation of the kitchen, a bag of chicken nuggets was opened and did not have an open date. The bag of chicken nuggets was not properly sealed. The bag appeared to have been rolled closed, and it unrolled and was open. B. On [DATE] at 11:55 AM, during an interview, the Lead [NAME] confirmed the bag of chicken nuggets was open and not sealed properly. The Lead [NAME] also confirmed the bag of chicken nuggets did not have an open date. The lead [NAME] confirmed staff should seal and date the opened bag of chicken nuggets. C. On [DATE] at 12:00 PM, during an observation of the kitchen, revealed the following expired seasonings: 1. One container of parsley expired on [DATE]. 2. One container of basil expired on [DATE]. D. On [DATE] at 12:02 PM, during an observation of the kitchen revealed the following open items did not have an expiration date or a use by date: 1. One container of chili powder. 2. One container of ground thyme. 3. One container of ground coriander. 4. One container of Italian seasoning. 5. One container of granulated onion. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. One container of vanilla extract. E. On [DATE] at 12:08 PM, during an interview, the Lead [NAME] confirmed the spices were expired and should have been thrown away. The Lead [NAME] confirmed the seasonings were not labeled with open dates or use by dates. The Lead [NAME] confirmed the staff were supposed to date the seasonings when they opened them so they knew how old they were.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49313 Based on record review and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections when they failed to have a water management program to minimize the risk of Legionella [a bacteria that can grow in parts of building water systems that are continually wet (e.g., pipes, faucets, water storage tanks, decorative fountains) and cause a serious type of pneumonia] and other opportunistic pathogens (bacteria that do not usually cause diseases in healthy people but may become extremely injurious to unhealthy individuals) in the building's water system. This failure could potentially affect all 43 residents who lived in the facility (residents were identified by the Resident Matrix provided by the DON on 08/26/24). If the facility fails to maintain an effective infection control program, then infections could spread to residents throughout the facility, resulting in illness. The findings are: A. Record review of the facility's Water Management Program for Building Water Systems: Governing Guideline, dated 04/05/19, the following was revealed: 1. The administrator was responsible for the overall Program compliance. 2. The Environmental Services Director or designee was responsible for the overall implementation of the program design for the systems and the daily operation, maintenance, and monitoring duties of the program. B. Record review of the facility's Water Management Program For Building Water Systems: Site Management Plan, dated 04/09/19, revealed the section of the plan that identified facility team members that were responsible for the implementation of the plan was blank. C. On 08/28/24 at 10:47 AM, during an interview, the DON stated the following: 1. She was the individual responsible for infection prevention. 2. She did not complete any Legionella or waterborne pathogen assessment or prevention. 3. She was not aware of who was responsible for water management or the prevention of Legionella and other waterborne pathogens. D. On 08/28/24 at 11:01 AM, during an interview, the Maintenance Worker stated the following: 1. The facility did not have a Maintenance Director. 2. The Maintenance Worker worked at the facility for four years. 3. He was unaware of any water management program the facility had to minimize the risk of Legionella and other opportunistic waterborne pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. He did not have a map or diagram of the water system and potential sources for the growth of waterborne pathogens. 5. He was unaware of where Legionella or other waterborne pathogens could grow. E. On 08/28/24 at 2:17 PM, during an interview with the Environmental Services Director for Housekeeping and Laundry, she confirmed the following: 1. She was unaware of any water management program the facility had to minimize the risk of Legionella and other opportunistic waterborne pathogens. 2. She did not have a map or diagram of the water system and potential sources for the growth of waterborne pathogens. 3. She was unaware of where Legionella or other waterborne pathogens could grow. F. On 08/28/24 at 3:36 PM, during an interview with the DON, she confirmed the following: 1. The facility Water Management Plan did not have any team members listed as being part of the Program Management Team. 2. She was unable to identify which staff members were on the Program Management Team or what staff members were responsible for performing water management tasks.