STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahoskie Health and Rehabilitation Center	604 Stokes Street East Ahoskie, NC 27910

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff interviews, and resident interview, the facility failed to hold a care plan meeting or invite the resident to participate in the care planning process for 1 of 22 residents whose care plans were reviewed (Resident #62). The findings included: Resident #62 was admitted to the facility on [DATE]. Review of the Multidisciplinary Care Conference assessment dated [DATE] revealed a quarterly care plan meeting was conducted for Resident #62. Review of the Multidisciplinary Care Conference assessment dated [DATE] revealed a quarterly care plan meeting was conducted for Resident #62. Review of the Multidisciplinary Care Conference assessment dated [DATE] revealed a quarterly care plan meeting was conducted for Resident #62. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #62 had moderate cognitive impairment. Resident #62 was coded for active participation in the assessment and goal setting. Review of Resident #62's electronic medical record revealed no documentation that a care plan meeting was held or that Resident #62 was invited to participate in a care plan meeting during the time between the 11/28/23 and 7/02/24 care plan meetings. During an interview with Resident #62 on 9/23/24 at 10:16 am, Resident #62 reported she was unable to recall the last time she had a care plan meeting, but she wanted to be involved with her care plan meetings. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/24/24 at 1:05 pm with the Director of Social Services who revealed she was responsible to invite the resident and/or the Responsible Party (RP) to participate in the quarterly care plan meetings. She stated she personally invited the residents to participate in the quarterly care plan meetings when they were scheduled. The Director of Social Services reported she was unable to locate any documentation that a care plan meeting was held for Resident #62 between the 11/28/23 and 7/02/24 care plan meetings but she stated there should have been one held during that time frame. An interview was conducted with MDS Nurse #2 on 9/24/24 at 1:14 pm who revealed the long-term resident care plan meetings were held quarterly (every 3 months). MDS Nurse #2 stated MDS Nurse #1 created a care plan meeting calendar and would give the calendar to the Director of Social Services to schedule the resident care plan meeting. MDS Nurse #2 stated Resident #62 should have had a care plan meeting between the 11/28/23 and 7/02/24 care plan meetings but she was unable to locate any documentation that the meeting was scheduled or completed. During an interview on 9/26/24 at 10:32 am with MDS Nurse #1 she revealed she was responsible to create a care plan meeting calendar based on the resident assessment dates which were every 3 months for long-term care residents. She stated she created the care plan meeting calendar that noted the residents that required a care plan meeting to be scheduled for a particular month. MDS Nurse #1 stated she gave the calendar of residents that required a care plan meeting to the Director of Social Services to schedule and invite the resident to the care plan meeting. MDS Nurse #1 stated Resident #62 should have been on the calendar to have a care plan meeting sometime around the March 2024 time frame for her next care plan meeting after the 11/28/23 care plan meeting. MDS Nurse #1 was unable to locate the care plan meeting calendar to confirm Resident #62 was listed to have the meeting scheduled, but she stated she thought Resident #62's name was listed. A follow-up interview was conducted on 9/26/24 at 12:21 pm with the Director of Social Services who revealed if Resident #62 was listed on the care plan meeting calendar created by MDS Nurse #1 she would have scheduled a care plan meeting to be held. The Director of Social Services stated Resident #62 should have had a care plan meeting scheduled sometime between the end of February 2024 through early March 2024 based on the last care plan meeting date, but she must not have been on the care plan calendar list provided by MDS Nurse #1. An interview was conducted on 9/26/24 at 12:43 pm with the Administrator who revealed MDS Nurse #1 was responsible to ensure the care plan meeting calendar was completed accurately and communicated appropriately to the Director of Social Services to create the schedule.

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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** 45045 Based on observation, record review, and staff and resident interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of a pressure reducing surface for pressure ulcer (Resident #7) and the use of a continuous positive airway pressure (CPAP) machine (Resident #95) for 2 of 22 residents whose MDS assessments were reviewed. The findings included: 1. Resident #7 was admitted to the facility on [DATE]. Resident #7 had an active physician order dated 4/19/24 for a standard pressure ulcer redistribution mattress. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment and was coded for an unhealed, unstageable (due to coverage of the wound bed by slough and/or eschar) pressure ulcer. Resident # 7 was not coded for a pressure reducing surface for bed. An interview was conducted on 9/24/24 at 3:19 pm with MDS Nurse #2 who completed Resident #7's MDS quarterly assessment. MDS Nurse #2 confirmed Resident #7 had a physician order for the standard pressure ulcer redistribution mattress and stated Resident #7's mattress was a pressure reducing surface for the bed. MDS Nurse #2 stated she should have coded the mattress as a pressure reducing surface for bed for Resident #7's quarterly assessment. During an interview on 09/26/24 at 12:38 pm with the Administrator she revealed the MDS Nurse was responsible to code Resident #7's MDS assessment accurately. 2. Resident #95 was admitted to the facility on [DATE] with diagnoses which included obstructive sleep apnea and acute respiratory failure with hypoxia. Resident #95 was noted to be discharged to the hospital on 8/19/24 and returned to the facility on [DATE]. Resident #95 had a care plan initiated on 2/02/24 for oxygen therapy related to continuous positive airway pressure (CPAP) related to obstructive sleep apnea with an intervention to encourage to wear the CPAP as ordered by the physician. Resident #95 had an active physician order dated 8/26/24 for CPAP machine to apply at bedtime and remove when awake for sleep apnea. Review of the medication administration record for the month of August 2024 revealed Resident #95 used the CPAP machine as ordered with the exception of 8/28/24 which was noted as refused. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #95 was cognitively intact and was not coded for use of a CPAP machine. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview were conducted on 9/23/24 at 10:24 am with Resident #95 who had a CPAP machine located on the bedside table. Resident #95 revealed she had the CPAP machine for a long time and did use it at night while sleeping. An interview was conducted on 9/24/24 at 1:31 pm with MDS Nurse #1 who revealed if Resident #95 used the CPAP it should have been coded on the assessment. MDS Nurse #1 stated she reviewed the MDS assessment, and she did not have the option to answer the question regarding Resident #95's CPAP use. A follow-up interview was conducted with MDS Nurse #1 on 9/24/24 at 3:10 pm who revealed she reviewed the Resident Assessment Instrument (manual used for completing the MDS assessments) and she found that in order to code Resident #95's CPAP she had to choose yes to mechanical ventilation first. MDS Nurse #1 stated she was not aware she had to answer the mechanical ventilation area first in order to accurately code Resident #95 for use of the CPAP. During an interview on 09/26/24 at 12:38 pm with the Administrator she revealed the MDS Nurse was responsible to code Resident #95's MDS assessment accurately.

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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 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** 45045 Based on record review, staff interviews, and resident interview, the facility failed to revise the care plan in the area of antipsychotic medication use (Resident #62) and risk for pain (Resident #101) for 2 of 22 residents reviewed for care plan revision. The findings included: 1. Resident #62 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, major depressive disorder, and cognitive communication deficit. Review of the Psychiatric Provider visit note dated 12/11/23 revealed Resident #62 was recommended to start olanzapine (an antipsychotic medication) 2.5 milligrams (mg) tablet at bedtime for mood instability related to dementia. Resident #62 had an active physician order dated 12/14/23 for olanzapine 2.5 mg at bedtime for mood instability related to dementia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #62 had moderate cognitive impairment and was coded for rejection of care for 1-3 days during the 7-day look back period. Resident #62 was coded for antipsychotic medications for 7 of the 7 days during the assessment period. Review of Resident #62's care plan last reviewed on 8/13/24 revealed no care plan in place for use of an antipsychotic medication. An interview was conducted on 9/26/24 at 10:08 am with the Interim Director of Nursing (DON) who revealed care plan revisions were completed by the MDS Nurse. During an interview on 9/26/24 at 10:20 am MDS Nurse #2 revealed the MDS Nurses were responsible to update resident care plans. MDS Nurse #2 stated the normal process was the new medication would be discussed in the clinical meeting by nursing and she would revise the care plan during the meeting. MDS Nurse #2 stated had the new medication been discussed at the clinical meeting by nursing she would have revised Resident #62's care plan, but she did not recall the new medication being discussed. An interview was conducted on 9/26/24 at 10:35 am with MDS Nurse #1 who revealed Resident #62's antipsychotic medication required a care plan. MDS Nurse #1 stated she normally did not revise resident care plans because it was MDS Nurse #2's responsibility. MDS Nurse #1 stated the care plan should have been revised by MDS Nurse #2 when Resident #62's antipsychotic medication was started. An interview with the Administrator was conducted on 9/26/24 at 12:46 pm who revealed she expected resident care plans to be revised as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #101 was admitted to the facility on [DATE] with diagnoses which included Parkinsonism (clinical syndrome characterized by tremor, slow movement, and rigidity). Resident #101 had an active physician order dated 3/02/24 for meloxicam (a nonsteroidal medication used to treat arthritis) tablet 7.5 milligram (mg) one time a day for chronic pain. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #101 had moderate cognitive impairment and was coded for a stage 3 pressure ulcer. Resident #101 was coded for use of scheduled pain medication. Review of Resident #101's care plan last reviewed on 7/24/24 revealed no care plan was in place for pain management. Review of the medication administration record (MAR) for August 2024 through September 2024 revealed Resident #101 was administered the meloxicam medication as ordered. An interview was conducted with Resident #101 on 9/23/24 at 12:39 pm who reported she often had aching pain to her right arm. Resident #101 stated she did report the pain when it starts to the nurses, but she was not sure if they gave her pain medication. An interview was conducted with Nurse #2 on 9/24/24 at 2:03 pm who revealed Resident #101 was on a scheduled pain medication that was administered every morning, and she had not reported right arm pain to her in the past. An interview was conducted on 9/26/24 at 10:08 am with the Interim Director of Nursing (DON) who revealed the MDS Nurses were responsible for resident care plans. During an interview on 9/26/24 at 10:15 am with MDS Nurse #2 she revealed Resident #101 was not taking a lot of pain medication and did not report a pain presence when she completed her assessment, so she did start a pain management care plan. MDS Nurse #2 stated she could have entered a risk for pain care plan, but she did not revise Resident #101's care plan when the meloxicam medication was ordered. An interview was conducted on 9/26/24 at 10:35 am with MDS Nurse #1 who revealed Resident #101 should have had a care plan in place for pain related to her scheduled pain medication and the stage 3 pressure ulcer. MDS Nurse #1 stated she normally did not revise resident care plans because it was MDS Nurse #2's responsibility. MDS Nurse #1 stated the care plan should have been revised by MDS Nurse #2 when Resident #101's pain medication was started. An interview with the Administrator was conducted on 9/26/24 at 12:46 pm who revealed she expected resident care plans to be revised as needed.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41772 Based on record review and staff interview the facility failed to designate a full-time Director of Nursing (DON) for the Skilled Nursing Facility (SNF) when the current DON went out on family medical leave. The findings included: During an interview with the Administrator on 9/23/24 at 9:53 AM, the Administrator explained that the Director of Nursing (DON) was out due to having surgery. She stated the DON had been available by phone when unable to physically be in the building due to these issues. The Administrator stated on 9/16/24 the DON had planned surgery and took medical leave at that time. The Administrator stated that the Staff Development Coordinator who was a registered nurse (RN) was the contact person for nursing-related questions. During an interview with the Staff Development Coordinator (SDC) on 9/24/24 at 2:48 PM, she stated she shared on call duty with the Wound nurse. The SDC reported staff would call her with nursing related questions after hours during her on call day. The Staff Development Coordinator stated she had not been informed that she was the DON designee. During a follow up interview with the Administrator on 9/26/24 at 9:17 AM, she stated she did not appoint an interim DON when the DON went out for surgery on 9/16/24. The Administrator stated on 9/25/24 the SDC was appointed as the interim DON.

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F 0744 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789 Based on record review and staff interviews, the facility failed to develop a care plan that addressed dementia care for 1 of 3 residents reviewed for comprehensive care plans (Resident #39). The findings included: Resident #39 was admitted to the facility on [DATE] with diagnoses that included Dementia and Insomnia. Review of Resident #39's care plan updated on 8/7/2024 revealed a focus area for dementia was not reflected in the care plan. A review of Resident #39's Nursing progress note dated 9/21/2024 at 11:18 P.M. revealed the resident refused the previous shift nurse to complete wound care. In an interview with Nurse #12 on 9/25/2024 at 12:03 P.M. she revealed Resident #39 had behaviors which included refusing wound care and medications or forcing his way to the smoking area outside smoking times. During an interview with MDS Nurse #2 on 9/24/2024 at 12:10 P.M. she revealed it was her responsibility to ensure the diagnosis of Dementia was care planned. She further revealed the error of not updating the care plan was an oversite on her part. An interview was conducted with the Administrator on 9/25/2024 at 9:19 A.M. She revealed it was the responsibility of the Director of Nursing to ensure the care plans accurately reflected the resident's condition and diagnosis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on record review, staff interview and Consultant Pharmacist interview, the Pharmacist failed to identify and report a medication irregularity when an Abnormal Involuntary Movement Scale (AIMS) assessment was not initiated for Olanzapine (antipsychotic medication used to regulate behaviors) or 1 of 4 residents reviewed for unnecessary medications (Resident #57). The findings included: Resident #57 was admitted on [DATE] with diagnoses that included anxiety disorder and dementia with behavioral disturbance. A review of the physician's orders revealed an order for Olanzapine 10 MG (milligrams) (an antipsychotic medication used to regulate behaviors)- Give 1 tablet by mouth at bedtime for mood instability and hallucinations dated 1/17/23. Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was cognitively intact and was not coded for behaviors. Resident #57 was coded for antipsychotic medications for 7 of the 7 days during the assessment period. Review of Resident #57's electronic medical record from 8/10/23 to 9/26/24 revealed no documentation regarding the completion of an AIMS assessment. Review of the Monthly Medication Regimen (MRR) for Resident #57 revealed the Pharmacy Consultant reviews were completed on the following days: 9/17/23, 10/17/23, 11/8/23, 12/18/23, 1/22/24, 2/25/24, 3/24/24, 4/23/24, 5/22/24, 6/16/24, 7/23/24, and 8/22/24. There were no recommendations made by the Consultant Pharmacist for completion of an AIMS assessment. Review of the care plan last reviewed on 7/10/24 revealed Resident #57 used psychotropic medications due to hallucinations. The interventions included administering psychotropic medications as ordered by physician and monitoring for side effects. Further review of the care plan revealed Resident #57 exhibited behaviors of pulling off clothes, making inappropriate remarks to staff, and loud yelling. The interventions included approach/speak to resident in a calm manner, divert attention, and intervene as necessary to protect the rights and safety of others. A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months thereafter. The Consultant Pharmacist stated Resident #57 had been overlooked and the facility was responsible for completing the AIMS assessment once Resident #57 was started on the antipsychotic medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Senior [NAME] President of Clinical Operations on 09/26/24 at 11:09 AM. The Senior VP stated AIMS should be completed every 6 months for residents who are on antipsychotic medications. She further stated the AIMS assessments were to be reviewed during the at-risk meetings which involved the interdisciplinary team. During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45045 Based on record review, staff interviews, and Consultant Pharmacist interview, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for residents receiving an antipsychotic medication, which is used for medication monitoring of side effects of antipsychotic medication for 3 of 5 residents reviewed for unnecessary medications (Resident #7, Resident #62, and Resident #57). The findings included: 1. Resident #7 was admitted to the facility on [DATE] with diagnoses which included dementia with behaviors. Resident #7 had an active physician order dated 4/20/24 for quetiapine fumarate oral tablet (an antipsychotic medication) 25 milligrams (mg) give one tablet by mouth one time a day for dementia with behaviors. Resident #7 had an active physician order dated 4/22/24 for quetiapine fumarate oral tablet 50 mg at bedtime for behaviors. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment and was not coded for behaviors. Resident #7 was coded for antipsychotic medications for 7 of the 7 days during the assessment period. Resident #7 had a care plan last reviewed on 7/26/24 for use of psychotropic mediations related to dementia and behavior management with interventions to administer psychotropic medication as ordered by the physician, and to monitor for adverse reactions. A review of Resident #7's electronic medical record from 4/20/24 through 9/25/24 revealed no documentation regarding the completion of an AIMS assessment since the antipsychotic medication had been started. The AIMS assessment was utilized to detect Tardive Dyskinesia (involuntary repetitive movements which occurs following treatment with medication) in residents prescribed antipsychotic medications. A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months thereafter. The Consultant Pharmacist stated the facility was responsible to ensure the AIMS assessment was completed as required for Resident #7 when the antipsychotic medication was started. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 9/26/24 at 10:08 am with the Interim Director of Nursing (DON) who revealed Resident #7 was required to have an AIMS assessment for the antipsychotic medication when it was started. The Interim DON stated the medication orders were reviewed in the daily clinical meeting and the need for Resident #7's initial baseline AIMS assessment should have been identified during those meetings. During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication. 2. Resident #62 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease with early onset and major depressive disorder. Review of the Psychiatric Provider visit note dated 12/11/23 revealed Resident #62 was recommended to start olanzapine (an antipsychotic medication) 2.5 milligrams (mg) tablet at bedtime for mood instability related to dementia. Resident #62 had an active physician order dated 12/14/23 for olanzapine 2.5 mg at bedtime for mood instability related to dementia. Review of Resident #62's electronic medical record revealed an AIMS assessment was completed on 1/25/24 for the start of the olanzapine medication. The AIMS assessment was utilized to detect Tardive Dyskinesia (involuntary repetitive movements which occurs following treatment with medication) in residents prescribed antipsychotic medications. Further review of Resident #62's electronic medical record 2/01/24 through 9/25/24 revealed no documentation regarding the completion of an AIMS assessment since the baseline AIMS assessment was completed for the antipsychotic medication on 1/25/24. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #62 had moderate cognitive impairment and was coded for rejection of care for 1-3 days during the 7-day look back period. Resident #62 was coded for antipsychotic medications for 7 of the 7 days during the assessment period. Review of Resident #62's care plan last reviewed on 8/13/24 revealed no care plan in place for use of an antipsychotic medication. A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months thereafter. The Consultant Pharmacist stated he would have expected for the facility to have completed another AIMS assessment for Resident #62's antipsychotic medication within 6 months of the initial assessment. An interview was conducted on 9/26/24 at 10:08 am with the Interim Director of Nursing (DON) who revealed an AIMS assessment for the antipsychotic medication was required when the medication was started and then quarterly thereafter. The Interim DON stated the AIMS assessments were reviewed in the daily clinical meeting and the need for Resident #62's next AIMS assessment should have been identified during those meetings. The Interim DON was unable to recall if Resident #62's AIMS assessments due dates were discussed during the meetings. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication. 41772 3. Resident #57 was admitted on [DATE] with diagnoses that included anxiety disorder and dementia with behavioral disturbance. A review of the physician's orders revealed an order for Olanzapine10 (milligrams) MG (an antipsychotic medication used to regulate behaviors)-Give 1 tablet by mouth at bedtime for mood instability and hallucinations dated 1/17/23. Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was cognitively intact and was not coded for behaviors. Resident #57 was coded for antipsychotic medications for 7 of the 7 days during the assessment period. Review of Resident # 57's electronic medical record from 8/10/23 to 9/26/24 revealed no documentation regarding the completion of an AIMS assessment. Review of the care plan last reviewed on 7/10/24 revealed Resident #57 used psychotropic medications due to hallucinations. The interventions included administering psychotropic medications as ordered by physician and monitoring for side effects. Further review of the care plan revealed Resident #57 exhibited behaviors of pulling off clothes, making inappropriate remarks to staff, and loud yelling. The interventions included approach/speak to resident in a calm manner, divert attention, and intervene as necessary to protect the rights and safety of others. A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months thereafter. The Consultant Pharmacist stated Resident #57 had been overlooked and the facility was responsible for completing the AIMS assessment once Resident #57 was started on the antipsychotic medication. An interview was conducted with the Senior [NAME] President of Clinical Operations on 09/26/24 at 11:09 AM. The Senior VP stated AIMS should be completed every 6 months for residents who are on antipsychotic medications. She further stated the AIMS assessments were to be reviewed during the at-risk meetings which involved the interdisciplinary team. During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff interviews, and Medical Director interview, the facility failed to hold a blood pressure medication as ordered by the physician when the blood pressure was above the parameter for 1 of 1 resident reviewed for a significant medication error (Resident #101). The findings included: Resident #101 was admitted to the facility on [DATE] with diagnoses which included hypertension, heart failure, and atrial fibrillation. A physician order dated 3/18/24 for midodrine (a medication used to treat low blood pressure) 5 milligram (mg) tablet by mouth three times a day for hypotension (low blood pressure). Hold for systolic blood pressure (SBP) greater than 120 millimeters of mercury (mmHg). Review of the Medication Administration Record for July 2024 revealed Resident #101 was administered midodrine 15 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings: 7/1/24 at 8:00 am SBP was 134 mmHg and was administered by Nurse #1. 7/1/24 at 12 pm SBP was 142 mmHg and was administered by Nurse #1. 7/1/24 at 4:00 pm SBP was 138 mmHg and was administered by Nurse #1. 7/2/24 at 8:00 am SBP was 138 mmHg and was administered by Nurse #7. 7/2/24 at 12 pm SBP was 138 mmHg and was administered by Nurse #7. 7/2/24 at 4:00 pm SBP was 133 mmHg and was administered by Nurse #7. 7/6/24 at 4:00 pm SBP was 130 mmHg and was administered by Nurse #6. 7/11/24 at 8:00 am SBP was 124 mmHg and was administered by Nurse #4. 7/11/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #4. 7/18/24 at 12:00 pm SBP was 128 mmHg and was administered by Nurse #8. 7/22/24 at 8:00 am SBP was 139 mmHg and was administered by Nurse #8. 7/27/24 at 4:00 pm SBP was 122 mmHg and was administered by Nurse #1. 7/28/24 at 8:00 am SBP was 142 mmHg and was administered by Nurse #1. 7/28/24 at 12:00 pm SBP was 136 mmHg and was administered by Nurse #1. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/28/24 at 4:00 pm SBP was 124 mmHg and was administered by Nurse #1. Review of the Medication Administration Record for August 2024 revealed Resident #101 was administered midodrine 5 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings: 8/9/24 at 4:00 pm SBP was 128 mmHg and was administered by Nurse #5. 8/10/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #5. 8/12/24 at12:00 pm SBP was 127 mmHg and was administered by Nurse #5. 8/20/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #5. 8/23/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #5. Review of the nursing progress notes from July 2024 through August 2024 revealed no identified concerns related to the midodrine being administered to Resident #101 outside of the physician order parameters. An attempt to conduct a telephone interview with Nurse #8 on 9/25/24 at 1:15 pm was unsuccessful. An attempt to conduct a telephone interview with Nurse #7 on 9/25/24 at 1:59 pm was unsuccessful. During a telephone interview on 9/25/24 at 2:06 pm with Nurse #5 confirmed she worked at the facility on the dates the medication was signed out on the MAR. She revealed she normally checked Resident #101's blood pressure before she gave her midodrine and she recalled Resident #101's SBP normally being lower than order parameter. Nurse #5 reported the medication should have been held based on the SBP that was documented. Nurse #5 stated she cannot say what happened and why the medication was given. An attempt to conduct a telephone interview with Nurse #6 on 9/25/24 at 2:15 pm was unsuccessful. A telephone interview was conducted on 9/25/24 at 2:23 pm with Nurse #4 who revealed when a blood pressure medication had a parameter to hold a blood pressure was supposed to be obtained prior to administration of the medication. Nurse #4 stated she did not recall the particular dates she was assigned to Resident #101, but she stated the midodrine should have been held if the SBP was greater than 120 mmHg. Nurse #4 could not say why she gave the medication. A telephone interview was conducted on 9/25/24 at 6:00 pm with Nurse #1 who revealed she did not recall Resident #101or the specific dates to respond to the questions. Nurse #1 stated that in general if a blood pressure medication had a parameter, she would have obtained the blood pressure prior to giving the medication and documented the blood pressure when she signed out the medication. Nurse #1 stated if she documented that she administered the medication she would not be able to say what happened and why she would have given the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 9/25/24 at 1:01 pm with the Nurse Practitioner who revealed she had only been at the facility for a few weeks and was unable to answer the questions regarding Resident #101. An attempt to conduct a telephone interview with the Medical Doctor who was assigned to Resident #101 on 9/26/24 at 11:39 am was unsuccessful. A telephone interview was conducted on 9/26/24 at 1:50 pm with the Medical Director who revealed Resident #101's midodrine was ordered with a parameter to keep the blood pressure from going too low. The Medical Director stated the risk associated with the midodrine being administered outside of the SBP parameter could have increased her blood pressure to an unsafe level which is why a parameter was placed on specific orders. The Medical Director stated Resident #101's midodrine should not have been administered when the SBP was greater than 120 mmHg. An interview was conducted on 9/26/24 at 9:58 am with the Interim Director of Nursing (DON) who revealed nurses were educated regarding medication administration including to hold medications when outside of an order parameter. The Interim DON stated nurses were to check the blood pressure prior to the medication being administered. The Interim DON stated the Nurses should not have administered Resident #101's midodrine when the SBP was greater than the parameter of the physician order.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on observations, record review, and interviews with resident, Speech Language Pathologist, Registered Dietitian, and staff, the facility failed to honor food preferences for 1 of 4 residents reviewed for preferences (Resident #66). The findings included: Resident #66 was readmitted to the facility on [DATE]. Diagnoses included severe protein calorie malnutrition, failure to thrive, diabetes, and dysphagia. An admission Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #66 with adequate hearing/vision, understood, understands, clear speech, severely impaired cognition. A diet order for Resident #66 dated 9/15/23 recorded a regular diet with mechanical soft ground meat texture on a sectioned plate with thin liquids, and double portions. Review of Diet Order and Communication form dated 9/15/24 for Resident #66 revealed a new diet order that included mechanically altered level 2, thin liquids, and double portions on a sectioned plate. A Nutritional Review dated 9/20/24, completed by the Registered Dietitian (RD), recorded Resident #66 for a regular, mechanical soft, ground meat texture; double portions diet order. Her intake varied from 25-75% consumption of meals. She had a wound noted to the right buttocks. The current diet order met nutritional requirements, but Resident #66 had variable intake. Wound healing interventions needed. Resident #66 was interviewed on 9/24/24 at 8:36 AM. She stated that she was supposed to receive double portions at meals but had yet to receive. During an observation on 9/25/24 at 8:52 AM, Resident #66 did not receive double portions of food items on breakfast meal tray, including eggs and oatmeal. The meal ticket did not include the details of double portions. During an observation on 9/25/24 at 12:58 PM, Resident #66 did not receive double portions of food items on the lunch meal tray, including ground meat, rice, and creamed corn. The meal ticket did not include the details of double portions. The Dietary Manager (DM) was interviewed on 9/25/24 at 1:05 PM. She revealed that all diet order changes were communicated with a Diet Order and Communication form from the nurse on duty. She stated she was not notified that the order change on 9/15/24 included double portions. The DM indicated that Resident #66 ate a lot of snacks/cookies and drank fluids, but she did not eat most of her meals. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Speech Language Pathologist (SLP) on 9/25/24 at 2:13 PM, she revealed that if she initiated a diet change for a resident, a copy would be given to the Director of Rehab, the RD, and the nurse on duty. The SLP stated that Resident #66 asked for double portions on 9/15/24 because she was still hungry after meals. So, the SLP gave the Diet Order and Communication form to kitchen staff (names unknown) and the nurse on duty assigned to Resident #66. An interview was conducted with the RD on 9/25/24 at 2:47 PM. She revealed that she was aware of Resident #66's double portions diet order, but the description seemed vague and left a lot of room for interpretation. The RD indicated she needed to clarify the double portions order with the SLP as to double protein or double entrees. The interview further reveaked if Resident #66 requested more food and was included in the diet order, then she should receive double portions. Nurse #10 was interviewed on 9/25/24 at 3:32 PM. She revealed that when she was given a Diet Order and Communication form, she would take it to the kitchen. Nurse #10 stated she could not recall if she was given a Diet Order and Communication form from the SLP on 9/15/24. During an interview with the Senior [NAME] President of Operations on 9/25/24 at 3:25 PM, she revealed that the RD told her Resident #66's request for double portions was considered a preference. If the DM was not in the building when a food preference/dietary change was made, then there needed to be a process in place to ensure clear communication. She stated she would expect any changes to a dietary order or food preference to be fulfilled and carried out. The Administrator was interviewed on 9/26/24 at 8:49 AM. She revealed that Resident #66 asked for double portions, and dietary staff should have been alerted to the change and provided her preference at meals.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review and staff interviews, the facility failed to accurately document the administration of 14 doses of blood pressure medication in the medical record for 1 of 1 resident reviewed for a significant medication error (Resident #101). The findings included: Resident #101 was admitted to the facility on [DATE] with diagnoses which included hypertension, heart failure, and atrial fibrillation. A physician order dated 3/18/24 for midodrine (a medication used to treat low blood pressure) 5 milligram (mg) tablet by mouth three times a day for hypotension (low blood pressure). Hold for systolic blood pressure (SBP) greater than 120 millimeters of mercury (mmHg). Review of the Medication Administration Record for July 2024 revealed Resident #101's midodrine was documented as administered 2 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings: 7/4/24 at 4:00 pm SBP was 132 mmHg and was documented as administered by Nurse #3. 7/10/24 at 4:00 pm SBP was 128 mmHg and was documented as administered by Nurse #3. Review of the Medication Administration Record for August 2024 revealed Resident #101's midodrine was documented as administered 8 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings: 8/2/24 at 12:00 pm SBP was 128 mmHg and was documented as administered by Nurse #3. 8/8/24 at 12:00 pm SBP was 132 mmHg and was documented as administered by Nurse #2. 8/14/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2. 8/17/24 at 12:00 pm SBP was 124 mmHg and was documented as administered by Nurse #2. 8/21/24 at 8:00 am SBP was 132 mmHg and was documented as administered by Nurse #2. 8/22/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2. 8/28/24 at 8:00 am SBP was 122 mmHg and was documented as administered by Nurse #2. 8/31/24 at 4:00 pm SBP was 124 mmHg and was documented as administered by Nurse #2. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record for September 2024 revealed Resident #101's midodrine was documented as administered 4 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings: 9/1/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2. 9/11/24 at 4:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2. 9/15/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2. 9/19/24 at 4:00 pm SBP was 121 mmHg and was documented as administered by Nurse #2. An interview was conducted on 9/25/24 at 1:01 pm with Nurse #2 who revealed when a physician order had a parameter to hold the medication the order required a blood pressure to be obtained and documented on the Medication Administration Record (MAR). Nurse #2 stated she did not believe she administered the midodrine medication to Resident #101 on the dates noted because she always paid attention to the medication order. Nurse #2 stated does not think she gave the medication outside the parameter because she knows Resident #101 well. An interview was conducted on 9/25/24 at 1:09 pm with Nurse # 3 who revealed she checked Resident #101's blood pressure prior to administering the midodrine medication and would enter the blood pressure when she documented the medication as administered. Nurse #3 stated it may have been a documentation mistake, but she did not think she would have administered Resident #101's midodrine medication outside of the parameter. An interview was conducted with the Interim Director of Nursing (DON) on 9/26/24 at 9:58 am who revealed all nursing staff were provided education during orientation and random medication pass observations throughout the year to ensure medications were being administered correctly. The Interim DON stated the education included documentation of the medications administered.