STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375320	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rainbow Health Care Community and Rainbow Assisted	111 East Washington Bristow, OK 74010

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 35474 Based on record review and interview, the facility failed to ensure residents were offered the opportunity to formulate an advance directive for one (#31) of three sampled residents who were reviewed for advance directives. The DON identified 76 residents who resided in the facility. Findings: The Advanced Directives policy, dated 04/26/23, read in part, .Upon Admission the Facility will provide Resident who is Medically Deemed Competent or Resident Representative, who does not have an existing Advance Directive, with written information and instructions regarding the Right to make Advance Directives prior to the initiation of Care or at any requested time . Resident #31 had diagnoses which included unspecified dementia. The face sheet for Resident #31 documented the resident was a full code. Review of the electronic clinical record did not reveal the resident had been offered the option to formulate an advance directive. On 02/27/24 at 3:10 p.m., the social services director stated they would review the clinical record for documentation related to the advance directive. On 02/27/24 at 3:51 p.m., the social services director stated they did not have information regarding formulating an advance directive for Resident #31.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47751 Based on observation and interview, the facility failed to ensure a sanitary environment in the shower rooms. The DON identified 76 residents who reside at the facility. Findings: A Quality of Life-Homelike Environment policy, dated 02/01/16, read in part, .2. The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .a. Cleanliness and order . A Resident Council Meeting form, dated 02/13/24 documented the residents stated that the shower rooms were not cleaned up after the previous shower. On 02/26/24 at 10:52 a.m., the shower room located on Park Place Hall was observed to have hard water/lime/calcium deposits on the faucet. There was also a thick black substance in the corners of the shower stall and between the floor tile grout lines. The silicone caulking was coming loose from the corners of the shower stall walls and between the floor tiles and had a thick black substance underneath it. On 02/27/24 at 8:16 a.m., the shower room located on Hummingbird Hall was observed to have hard water/lime/calcium deposits on the shower wall and the faucet of the shower stall. The floor tiles were missing, exposing concrete, and the other floor tiles had deep cracks and divots. On 02/27/24 at 8:34 a.m., the shower room located on Southwest Hall was observed to have hard water/lime/calcium deposits on the faucet. There was also a thick black substance in the corners of the shower stall and on the baseboards in the shower room. All three shower rooms had an abundance of dirt and debris in the floors and behind the toilets. On 02/27/2 at 9:05 a.m., the housekeeping supervisor was made aware of the above findings. They stated they had been unable to get the showers clean because there was no drain for the water to drain, resulting in the thick black substance building up in the shower rooms.

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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** 41809 Based on observation, record review and interview, the facility failed to ensure care plans were reviewed and revised for two (#16 and #43) of nine residents who were reviewed for care plans. The DON identified 76 residents who reside at the facility. Findings: The Care Plan for Resident #43, initiated 11/03/23, documented a fall risk focus for mobility. The care plan documented the resident was a fall risk due to weakness affecting the left dominant side. Last revised 02/28/24. The care plan documented Resident #43 would not sustain serious injury through the review date, and to notify the physician of fall with recent medication changes. The care plan documented to ensure proper body alignment/position while in bed, ensure the call light was within reach and encourage use for assistance as needed. There was no mention of a fall mat placed next to the bed of Resident #43. 1. Resident #43 admitted with diagnoses which included hemiplegia, hemiparesis, and muscle weakness. The Care Plan for Resident #43, initiated 11/03/23, documented a fall risk focus for mobility. The care plan documented the resident was a fall risk due to weakness affecting the left dominant side. Last revised 02/28/24. The care plan documented Resident #43 would not sustain serious injury through the review date, and to notify the physician of fall with recent medication changes. The care plan documented to ensure proper body alignment/position while in bed, ensure the call light was within reach and encourage use for assistance as needed. There was no mention of a fall mat placed next to the bed of Resident #43. A Fall Incident report, dated 02/20/24, read in parts, Resident #43, .laying on floor parallel to bed on her back .rolled out of bed, change in condition compared to before hospitalization , bed in low position, fall mat in place . A Fall Incident report, dated 02/21/23, read in part, [Resident #43 was in the floor .I slid off the bed and hit my head and back .fall matt placed by bed . A fall risk evaluation completed 2/21/24 documented one to two falls in the last 3 months, with a fall risk score of 19. On 02/25/24 at 4:11 p.m., a fall mat was observed on the floor not next the bed, but in the middle of the room. An Incident Note, dated 02/25/24, read in part, .Resting quietly in bed w/ eyes closed .Cont [continue] on FFU [fall follow up] w/o [without] injury. Bed in lowest position w [with]fall mat in place. Call light and personal items in reach. Will cont to observe for changes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/29/24 at 9:33 a.m., Resident #43 was observed in bed, with their bedside table over them. No fall mat was observed in the room. On 02/29/24 at 9:45 a.m., CNA #8 stated the interventions in place to prevent injury from fall were a lowered bed. They stated they were not aware of any other interventions. CNA #8 stated they were made aware of interventions through report from the nurse or shift report. On 02/29/24 at 10:43 am, LPN #6 stated the interventions in place to prevent injury from fall were proper body alignment while bed, call light in reach, prompt response to requests, education on safety reminders and what to do if a fall occurs. LPN #6 was asked if a fall mat was in place. LPN #6 went to speak with the MDS coordinator and stated they thought there was an intervention for a fall mat. On 02/29/24 at 10:49 a.m., LPN #6 returned, stated no fall intervention for a fall mat was included on the care plan. On 02/29/24 at 10:56 a.m., the DON stated there was a fall mat, but it was removed because the resident was able to push it away. They stated they were having someone put a beveled fall mat next to the bed right now, they then nodded to a staff in the office, who left the room. The DON was asked why the care plan was not updated. The MDS coordinator stated the care plan should have been updated. 47751 2. Res #16 had diagnoses that included abnormalities of gait and mobility, muscle wasting, lack of coordination, generalized weakness, HTN, seizures, and Parkinson's Disease. An ADL and mobility care plan, dated 03/05/23, included bed mobility that did not reflect the resident s use of their two quarter rails. A significant change assessment dated [DATE] documented that the resident's cognition was intact, they required extensive assistance with most ADLs, and they had no impairment to their extremities. A quarterly assessment, dated 12/27/23, documented that the resident's cognition was intact, required moderate assistance with most ADLs and had impairment to one side of their upper extremities. On 02/25/24 at 10:59 a.m., the resident was observed in their bed with two-quarter rails, one to each side of the top of their bed. Both quarter rails were pulled up. The resident was awake and alert in their room and watching television. The resident was asked what they used the bed rails for. They stated to pull myself up in bed. On 02/27/24 at 2:37 p.m., the ADON reviewed the resident's care plan and confirmed it needed to be updated to reflect the use of the quarter bedrails. They stated that the care plan should have been updated to reflect the current resident's status and needs.

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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 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. 41809 Based on observation, record review and interview, the facility failed to ensure fall mats were properly placed for two (#43 and #10) of two resident who were reviewed for accident hazards. The DON identified # residents who were at risk for falls. Findings: An Accident & Incident Documentation & Investigation policy, revised 04/26/23, read in parts, .The Licensed Nurse shall document the Incident and notify the supervisor and Director of Nursing for follow through as needed .The licensed Nurse may complete a Nurses' Note and update the Resident Care Plan as needed . 1. Resident #43 admitted with diagnoses which included hemiplegia, hemiparesis, and muscle weakness. A Fall Incident report, dated 02/20/24, read in parts, Resident #43, .laying on floor parallel to bed on her back .rolled out of bed, change in condition compared to before hospitalization , bed in low position, fall mat in place . A Fall Incident report, dated 02/21/23, read in parts, [Resident #43 was in the floor .I slid off the bed and hit my head and back .fall matt placed by bed . A fall risk evaluation completed 2/21/24 documented one to two falls in the last 3 months, with a fall risk score of 19. On 02/25/24 at 00:00 p.m., a fall mat was observed on the floor not next to the bed, but in the middle of the room. An Incident Note, dated 02/25/24, read in part, .Resting quietly in bed w/ eyes closed .Cont [continue] on FFU [fall follow up] w/o [without] injury. Bed in lowest position w [with]fall mat in place. Call light and personal items in reach. Will cont to observe for changes. On 02/29/24 at 9:33 a.m., Resident #43 was observed in bed, with their bedside table over them. No fall mat was observed in the room. On 02/29/24 at 9:45 a.m., CNA #8 stated the interventions in place to prevent injury from fall were a lowered bed. They stated they were not aware of any other interventions. CNA #8 stated they were made aware of interventions through report from the nurse or shift report. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/29/24 at 10:43 am, LPN #6 stated the interventions in place to prevent injury from fall were proper body alignment while bed, call light in reach, prompt response to requests, education on safety reminders and what to do if a fall occurs. LPN #6 was asked if a fall mat was in place. LPN #6 went to speak with the MDS coordinator and stated they thought there was an intervention for a fall mat. On 02/29/24 at 10:49 a.m., LPN #6 returned, stated no fall intervention for a fall mat was included on the care plan. On 02/29/24 at 10:56 a.m., the DON stated there was a fall mat, but it was removed because the resident was able to push it away. They stated they were having someone put a beveled fall mat next to the bed right now, they then nodded to a staff in the office, who left the room. The DON was asked why the care plan was not updated. The MDS coordinator stated the care plan should have been updated. 2. Resident #10 was admitted with diagnoses which included, hemiplegia, hemiparesis, history of falls, muscle wasting and atrophy. A review of falls revealed Resident #10 had fallen on the following dates 12/25/23, 12/23/23, 12/17/23, 10/20/23, 10/15/23, 10/11/23, 10/2/23, 9/16/23 x 3. A Care Plan, revised 08/09/20, documented a fall risk related to balance and a history of falls, with interventions which included staff to perform more frequent checks on Resident #10 in early morning hours, and remind Resident #10 to ask for assistance with transfers and to not lean forward in their wheelchair. The care plan documented a beveled fall mat was to be placed by the bed of Resident #10 to reduce risk of injury and to ensure the fall mat was at bedside while the resident was in bed. On 02/29/24 at 11:30 a.m., an observation of a blue unbeveled fall mat was underneath the bed of Resident #10. Resident #10 was observed to be in the bed with eyes closed. On 02/29/24 at 12:48 p.m., an observation of a fall mat was underneath the bed of Resident #10 and the resident was in bed with their eyes closed. On 02/29/24 at 1:00 p.m., CNA #9 stated a fall mat was one of the interventions in place to prevent injury due to falls. They stated the fall mat was to be place in front of the bed. They stated the fall mat was currently under the bed. CNA #9 reached under the bed and pulled a blue unbeveled fall mat out from under the bed. They stated Resident #10 gets up and down on their own and sometimes pushes the fall mat under the bed. They stated the hospice for Resident #10 brought the fall mat. CNA #8 stated the aides were responsible to ensure the fall mat was in place. On 02/29/24 at 12:52 p.m., LPN #6 stated the resident should have a beveled fall mat. LPN #6 observed the fall mat and stated the fall mat was not beveled. They stated nursing was responsible to ensure the proper mat was in place. On 02/29/24 at 2:30 p.m., the DON stated nursing was responsible to ensure the proper fall mat was used and appropriately placed. The DON stated they did not know why a beveled mat was not supplied by the hospice.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35474 Based on record review and interview the facility failed to ensure nutritional supplements were provided as ordered for one (#73) of seven residents who were reviewed for nutrition. The DON identified 19 residents who were ordered nutritional supplements. Findings: The Nutritional Supplements policy, dated 12/01/22, read in part, .The Facility will have a formulary of Nutritional Supplements to be utilized as interventions to help ensure nutritional needs are met. Supplements may be available through the Nutritional Services or Nursing Department . Resident #73 had diagnoses which included chronic obstructive pulmonary disease. An admission assessment, dated 01/05/24, documented the resident was cognitively intact for daily decision making. A physician order, dated 02/15/24, documented the resident was ordered a house shake twice daily for weight support. On 02/25/24 at 11:43 a.m., the resident stated they had not been receiving a nutritional supplement. The Care Plan, updated 02/27/24, documented the resident had weight loss related to diuretic use and had house shakes twice daily for nutritional/weight support. Review of the February 2024 MARs and TARs did not reveal documentation the resident was receiving the house shake twice daily. On 02/29/24 at 12:33 p.m., LPN #6 stated Resident #73 had an order for a house shake twice daily. They stated the nursing department had not been administering the nutritional supplement and the dietary department had not been made aware of the order. On 02/29/24 at 12:36 p.m., the ADON stated the resident had been ordered a nutritional supplement on 02/15/24 but it had not been put on the MAR or TAR but it was to be sent on the meal tray by the dietary department. On 02/29/24 at 12:49 p.m., the dietary manager stated they had not been sending the nutritional supplement on the meal tray for Resident #73.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 35474 Based on record review and interview, the facility failed to ensure ongoing assessment including pre/post assessments were completed for two (#129 and #25) of two residents who were reviewed for dialysis. The DON identified four residents who received dialysis services. Findings: The Dialysis Communication policy, dated 09/27/23, read in part, .The top section of the Dialysis Communication Transfer From is completed by the Nurse responsible for sending the resident to the Dialysis Unit/Facility .The bottom section of the form is completed by personnel responsible for the resident at the Dialysis Facility and returned to the nursing home with the Resident .Once the form is completed, the most recent form should be stored in the medical record . 1. Resident #129 had diagnoses which included dependence on renal dialysis. The Baseline Care Plan, dated 02/21/24, documented the resident required dialysis. The Long Term Care Evaluation, dated 02/21/24, documented the resident was scheduled for dialysis Monday, Wednesday, and Friday and the location of the dialysis access was the left forearm. The undated, top portion, of the, Dialysis Communication Form, read in parts, .To be completed by Licensed Nurse for dialysis resident prior to dialysis treatment . The bottom portion of the form, read in parts, .To be completed by Dialysis Center following dialysis treatment, and to accompany resident on return to center . The top portion of the form was blank for current treatment/time, date, access site, and access condition. The bottom portion had been filled out by the dialysis nurse. The Dialysis Communication Form, dated 02/26/24, did not document the access site, access condition, weight, medications administered before dialysis, or the assessment prior to dialysis. Those sections of the form were left blank. On 02/26/24 at 11:19 a.m., LPN #6 reviewed the electronic clinical record and stated Resident #129 did not have orders for dialysis or monitoring. LPN #6 stated they did not perform any assessments when residents returned from dialysis. On 02/27/24 at 11:19 a.m., the DON stated the charge nurses obtained vital signs or would check on residents when they returned from dialysis. They stated the charge nurses did not complete an assessment but they reviewed vital signs on the communication form and would observe any dressings. The DON stated they missed putting orders in for dialysis and monitoring upon admission for Resident #129. They stated there was no documentation of the facility monitoring Resident #129 after dialysis or any other documented information before dialysis. 47751 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #25 had diagnoses that included end-stage renal disease, dependence on renal dialysis, and hypertension. A physician order, dated 11/26/22, documented remove dressing to fistula to LUE six hours after the resident returns from dialysis daily every Monday, Wednesday, and Friday. A physician order, dated 10/05/23, documented dialysis every Monday, Wednesday, and Friday at 10:30 a. m. at the dialysis center. Dialysis communication forms, dated 01/03/24 through 02/23/24, a total of 20 opportunities failed to document the nurse's name, current treatment time, access site, access condition, time of last meal, medication given pre-dialysis in addition to obtaining a pre-dialysis weight. The document had spaces to record the bruit/thrill, status of access graft/catheter, and skin issues with the access site. The pre-dialysis part of the form the nurse was responsible for completing was blank except for the vital signs. A care plan revised 01/14/24, documented: Assess my dialysis port/shunt for signs and symptoms of bleeding every shift and when I return from dialysis. Ensure that the dressing is dry, intact, and free from signs and symptoms of infection. Assess my vital signs and investigate abnormal findings. Monitor me for signs and symptoms of complications. A quarterly assessment, dated 02/07/24, documented the resident's cognition is moderately impaired and received renal dialysis. On 02/26/24, at 8:28 a.m., Res #25 was asked if the nurses were assessing his dialysis port when they returned from dialysis. They stated they were not. On 02/27/23 at 11:22 a.m., LPN # 1 was asked what the process was for completing dialysis pre- and post-communication forms. They stated they had not been completing them. They were shown resident #25's dialysis communication forms. They were asked why the form was blank except for the pre-dialysis vital signs. They stated they were unaware they were required to complete the form other than the vitals. On 02/27/24 at 1:19 p.m., the DON was asked what the process was for completing the dialysis pre and post-communication form. The DON stated the form was to be completed on the resident's dialysis days prior to departing from the facility and upon return to the facility.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47751 Based on record review, observation, and interview, the facility failed to assess the resident for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails with the resident or resident representative, and obtain an informed consent prior to installation for two (#11 and #16) of two sampled resident reviewed for side rails. The ADON identified four residents had grab bars/u-rails attached to their beds. Findings: 1. Res #11 had diagnoses which included diabetes, unsteadiness of feet, lack of coordination, anxiety, osteoporosis cerebral infarct, HTN, and CHF. A quarterly assessment, dated 01/17/24, documented the resident's cognition was intact, required substantial assistance with most ADLs, had impairment on one side of their upper and lower extremities, and was always incontinent of bowel and bladder. On 02/25/24 at 10:21 a.m., the resident was observed in their bed with one-quarter rail to the upper right side of the bed. The quarter rail was pulled up. The resident was awake and alert in their bed. The resident was asked what the bed rail was for. They stated they did not know. There was no evidence in EHR the resident had been assessed for risk of entrapment from bed rails prior to installation, review of the risks and benefits of bed rails with the resident or resident representative, and obtain an informed consent prior to installation. 2. Res #16 had diagnosis which included diabetes, COPD, abnormalities of gait and mobility, unsteadiness on feet, Parkinson's disease, anxiety, dementia, CHF, and insomnia. An ADL and mobility care plan, dated 03/05/23, included bed mobility that did not reflect the resident s use of their two quarter rails. A significant change assessment dated [DATE] documented that the resident's cognition was intact, they required extensive assistance with most ADLs, and they had no impairment to their extremities. A quarterly assessment, dated 12/27/23, documented that the resident ' s cognition was intact, required moderate assistance with most ADLs, and had impairment to one side of their upper extremities. There was no evidence in EHR the resident had been assessed for risk of entrapment from bed rails prior to installation, review of the risks and benefits of bed rails with the resident or resident representative, and obtain an informed consent prior to installation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/24 at 10:59 a.m., the resident was observed in their bed with two-quarter rails, one to each side of the top of their bed. Both quarter rails were pulled up. The resident was awake and alert in their room and watching television. The resident was asked what they used the bed rails for. They stated to pull myself up in bed. On 02/27/24 at 2:37 p.m., the ADON reviewed the residents' EHRs and confirmed there was no assessment conducted or informed consent obtained prior to the bed rail installation for resident's #11 and #16.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 35474 Based on record review and interview, the facility failed to ensure side effect monitoring was implemented for anticoagulant medications for two (#3 and #129) of six sampled residents whose medications were reviewed. The DON identified 12 residents who were ordered anticoagulant medications. Findings: 1. Resident #3 had diagnoses which included atrial fibrillation. The care plan, dated 10/10/23, documented the resident received Coumadin and had an increased risk of bleeding. The care plan documented to monitor for side effects. The MAR/TAR, dated December 2023, documented the resident received Coumadin (an anticoagulant/blood thinner) 2mg once daily. The MAR and TAR did not document side effect monitoring for the Coumadin. The MAR/TAR, dated January 2024, documented the resident received Coumadin 2mg once daily. The MAR and TAR did not document side effect monitoring for the Coumadin. The quarterly assessment, dated 01/17/24, documented the resident had received an anticoagulant medication during the look back period. The MAR/TAR, dated 02/01/24 through 02/27/24, documented the resident received Coumadin 2mg once daily from 02/01/24 through 02/25/24 and Coumadin 1.5mg once daily from 02/26/24 through 02/27/24. The MAR and TAR did not document side effect monitoring for the Coumadin from 02/01/24 through 02/27/24. On 02/28/24 at 2:02 p.m., LPN #6 stated side effect monitoring was documented on the TAR. They stated side effect monitoring for Resident #3 was not documented on the TAR. They reviewed the electronic health record for Resident #3 and stated the intervention to monitor for side effects related to anticoagulant use was missed upon readmission to the facility. On 02/29/24 at 11:53 a.m., the DON stated they did not have documentation side effects were monitored for Resident #3. On 02/29/24 at 12:45 p.m., the ADON stated charge nurses were to monitor for side effects of anticoagulant medications and document on the TAR. They stated the intervention to monitor for side effects of Coumadin for Resident #3 had not been put into the computer so it had not generated onto the TAR. 2. Resident #129 had diagnoses which included dependence on renal dialysis. The Order Summary Report, dated 02/26/24, documented an order for heparin (an anticoagulant/blood thinner) 5000units/ml inject one milliliter subcutaneously three times daily to start on 02/21/24. (continued on next page)

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	375320	A. Building B. Wing	03/01/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR/TAR, dated 02/21/24 through 02/26/24, documented the resident received heparin 5000units/ml as ordered. The MAR and TAR did not document side effect monitoring for the heparin. On 02/29/24 at 12:47 p.m., the DON stated side effect monitoring had not been put into the electronic clinical record so it had not generated onto the TAR.

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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. 47751 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was below five percent. A total of 28 opportunities were observed with two medication errors. Total medication error rate was 7.14%. The DON identified 76 residents resided in the facility. Findings: 1. Res #3 had diagnoses which included cellulitis, low protein, and low albumin levels. A physician order, dated 10/10/23, documented to administer Arginaid two times daily for wound support and low protein and albumin. On 02/26/24 at 7:32 a.m., CMA #2 was observed during medication pass and did not administer the Arginaid. The CMA was asked why they did not administer it. They stated because Res #3 always refuses it. They were asked if they offered the Arginaid to Res #3. They stated they did not and that the Arginaid needed to be discontinued from the MAR. The February 2024 MAR, documented the Res #3 had not taken the Arginaid 51 times for the month. 2. Res #40 had diagnoses which included constipation. A physician order, dated 03/13/23, documented to administer Miralax oral packet 17 GM in the morning and to mix with four to eight ounces of water/juice. On 02/26/23 at 7:45 a.m., CMA #2 was observed during medication pass and did not administer the Miralax. The CMA was asked why they did not administer it. They stated because Res #40 always refuses it. They were asked if they offered the Miralax to Res #40. They stated they did not and that the Miralax needed to be discontinued from the MAR. A medication administration record, dated February 2024, documented the resident had not taken the Miralax 26 times for the month. On 02/26/24 at 10:59 a.m., the cooperate nurse was made aware of the 7.14% med error rate. They asked what the errors were. They were informed the Arginaid was not offered to Res #3 and the Miralax was not offered to Res #40 and that both were marked as refused. They stated the CMA should have offered the medications to the residents.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 47751 Based on observation, interview, and record review, the facility failed to offer the residents an HS snack and ensure snacks were served to the residents in accordance with the facility policy, for three (#11, 16, and #25) of three sampled residents reviewed for food and nutrition services. The DON identified 76 residents resided in the facility. Findings: A facility policy titled, Meals & Snacks, dated 11/27/23, documented, .3. An evening snack shall be provided by Nutritional Services and offered to the residents by Nursing . On 2/26/24 at 11:43 a.m., the dietary manager was asked about the resident snack schedule. They stated dietary prepares snacks for the residents at 10 a.m., 2 p.m., and a bedtime snack around 7 p.m. They stated the snacks are placed at the nurse station. 1. Res #11 had diagnoses which included diabetes, protein-calorie malnutrition, and muscle wasting. On 02/25/24 11:52 a.m., Res #11 was asked if they were being offered a snack at bedtime. They stated they have never been offered a snack at bedtime. On 02/27/24 10:36 a.m., Res #11 was asked if they were offered a snack at bedtime last night. They stated they were not. 2. Res # 16 had diagnoses which included diabetes, muscle wasting, and anemia. On 2/25/24 Res #16 was asked if they were being offered a snack at bedtime. They stated they were not being offered a snack at bedtime. They stated if they wanted a snack they had to transfer to their wheelchair and propel themselves up the hall to the nurse station. They stated the bananas are black and over ripe and that dietary never offers apples or oranges and that they wished they would. On 02/27/24 10:42 a.m., Res #16 was asked if they were offered a snack at bedtime last night. They stated they were not. 3. Res #25 had diagnoses which included end stage renal disease and hyperlipidemia. On 02/25/24 1:22 p.m., Res #11 was asked if they were being offered a snack at bedtime. They stated they were not. They stated they got hungry at bedtime and would like a snack. On 02/27/24 10:56 a.m., LPN #1 was asked if the 10 a.m. snacks were brought to the nurse station. They stated they were not. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/27/24 at 11:05 a.m. the dietary manager was asked if the 10 a.m. snacks were brought to the nurse station. They stated they forgot and the snacks were not brought to the nurse station. On 02/27/24 at 1:14 p.m. the DON was made aware of the above stated. They stated they were not aware snacks were not being offered to the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41809 Based on observation, record review and interview, the facility failed to ensure the ice machine was clean. The DON identified # residents ate from the kitchen. Findings: A Nutritional Services Sanitation policy, reviewed 11/27/23, read in parts, .Nutritional Services shall ensure a clean and sanitary work environment; to promote to promote and protect food safety; and, to maintain compliance with Federal, State, and Local regulations governing food sanitation and safety .Cleaning of equipment .ice machines, etc shall be completed by the maintenance department .Equipment shall be cleaned, sanitized, delimed .in accordance with manufacturer recommendations . On 02/25/24 at 11:22 a.m., the ice machine was observed to have black and pink substances on the deflector plate in the bin of the ice machine. Ice was observed to be touching the deflector plate. On 02/25/24 at 11:23 a.m., [NAME] #1 stated they did not know what the substance was but it was disgusting. They stated it should not be served. On 02/25/24 at 1:30 p.m., the dietary supervisor stated the ice should not be used and the machine should be cleaned more frequently. The maintenance supervisor stated the ice machine was last cleaned on 02/20/24 when the filters were changed.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47751 Based on record review and interview, the facility failed to ensure arbitration agreements provided for the selection of a neutral arbitrator and a neutral venue agreed upon by both parties for one (#129) of two sampled residents who were reviewed for arbitration agreements. The administrator identified 76 residents who resided in the facility. Findings: A copy of the Agreement to Arbitration, provided by the administrator, read in part, .The Agreement .The parties choose to settle any future claims or controversies through binding arbitration administered by the American Health Lawyers Association (AHLA) .the arbitration will be at the Facility and conducted in accordance with the AHLA Rules . Resident #129 was admitted to the facility on [DATE]. Review of the clinical record revealed an Agreement to Arbitration, had been signed by the resident's representative on 02/22/24. The signature page of the agreement had been scanned into the electronic clinical record. On 02/27/24 at 11:27 a.m., the administrator was asked where in the arbitration agreement it was documented a neutral arbitrator agreed upon by both parties. The administrator reviewed the arbitration agreement and stated they did not find that verbiage in the document. The administrator was asked where in the arbitration agreement it was documented a convenient venue for both parties would be selected. The administrator stated they were not familiar with arbitration agreements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41809 Based on observation and interview, the facility failed to ensure staff followed infection control protocols while delivering meals to residents in the dining room. The administrator identified 76 residents who resided in the facility. Findings: On 02/25/24 at 12:41 p.m., the noon meal was observed in the dining room. DA #1 was observed to not sanitize their hands between plates. DA #1 was observed to touch their pants and facial hair net between delivering resident plates. DA #2 was observed to not sanitize their hands between resident plates while touching the rim of a cup of cobbler and touching their pants. On 02/25/24 at 12:49 p.m., DA #2 was observed to sanitize their hands, but continued to touch their pants. On 02/26/24 at 9:08 a.m., the Dietary Supervisor stated they expected staff to use hand sanitizer only if they cannot get to the sink and between plates.