STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375394	A. Building B. Wing	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoyah East Nursing Center, LLC	701 South Taylor Road Roland, OK 74954

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47751 Based on record review, observation, and interview, the facility failed to ensure resident call lights were in reach for one (#20) of 16 residents observed for call lights. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. Findings: A facility policy, titled, Answering the Call Light, revised October 2010, read in parts, .General Guidelines .5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident . Resident #20 had diagnoses which included cerebrovascular disease, vascular dementia with behavioral disturbance, seizures, and pain. A quarterly assessment, dated 09/15/23, documented the resident was severely impaired in cognition, was totally dependent on staff for most all ADL's, was incontinent of bladder and bowel, and received anti-anxiety and hypnotic medications. On 12/04/23 at 11:07 a.m., Res #20 was asked where their call light was. They stated they had not seen a call light in a very long time. The resident's call light was observed laying on a bedside table at the end of their bed. On 12/06/23 at 7:47 a.m., Res # 20's call light was observed on the floor underneath the end of their bed. On 12/06/23 at 7:50 a.m., LPN #2 was asked what the process was for call light placement. They stated the call light should be within the resident's reach. They were shown the resident's call light on the floor underneath the end of their bed. LPN #2 was asked if Res #20's call light was within their reach. They stated no but it should be. LPN #2 was asked if Res #20 was able to use the call light. LPN #2 handed Res #20 their call light and they were able to demonstrate using their call light without any issues. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/07/23 at 7:20 a.m., observed resident's call light clipped to their privacy curtain at the end of their bed. LPN #1 was in the resident's room and asked why the call light was clipped to the privacy curtain. They stated they did not know and clipped the call light to the sheet beside the resident's right hand. They were asked what the facility's policy was for call light placement. They stated the call lights are to be within the residents' reach at all times. On 12/07/23 at 10:49 a.m. the DON was made aware of Res #20 not being able to reach their call light on three separate occasions. They stated the staff would be re-educated on where to place the residents call light.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33148 Based on record review and interview, the facility failed to ensure a comprehensive resident assessment was completed for one (#39) of 13 sampled residents whose clinical records were reviewed for resident assessments. The administrator identified 45 residents resided in the facility. Findings: Res #39 was admitted to the facility on [DATE] with diagnoses which included dementia with agitation, pain, HTN, and pain. The EHR documented an annual resident assessment was due on 11/07/23 and the status of the assessment was late. On 12/05/23 at 10:01 a.m., MDS Coordinator #1 was asked when the annual resident assessment was completed for the resident. They reviewed the EHR and stated they missed completing the annual assessment.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47751 Based on record review and interview, the facility failed to complete a significant change assessment within 14 days after a resident received hospice services for one (#25) of three sampled residents who were receiving hospice services. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. Findings: Resident #25 was admitted to the facility on [DATE] and had diagnoses which included severe dementia with agitation, chronic atrial fibrillation, and hypertension. A significant change in status assessment, dated 01/11/23, documented the resident was moderately cognitively impaired, and required extensive assistance with most all activities of daily living. A physician order, dated 03/07/23, documented to admit the resident to hospice services. On 12/05/23 at 11:24 a.m., the MDS coordinator was asked if a significant change assessment had been completed within 14 days of the resident being admitted to hospice services. They stated a significant change assessment was not completed within the required time frame but should have been.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33148 8. Res #27 had diagnoses which included COPD, GERD, type 2 diabetes mellitus, unspecified viral hepatitis C, pain, depression, and anxiety. The EHR documented a quarterly resident assessment was due on 11/06/23 and the status of the assessment was late. On 12/06/23 at 12:47 p.m., MDS Coordinator #1 was asked when the last quarterly resident assessment was completed for the resident. They reviewed the EHR and stated a quarterly assessment was due on 11/06/23. They stated it was not completed. 46387 Based on record review and interview, the facility failed to ensure residents were assessed every three months using the quarterly review instrument for eight (#2, 18, 25, 26, 27, 35, 40, #42) of 15 sampled residents whose MDS assessments were reviewed. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. Findings: The Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual Version 1.18.11 October 2023 documented in part .RAI OBRA-required Assessment Summary .Quarterly (Non-comprehensive) . Regulatory Requirement .(every 3 months) .Assessment Completion refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete .For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (item Z0500) completion attestation . 1. Res #2 had a quarterly MDS dated [DATE]. A quarterly MDS, dated [DATE], was not signed as completed until 12/02/23. 2. Res #18 had a quarterly MDS dated [DATE]. A quarterly MDS, dated [DATE], was not signed as completed until 12/02/23. 3. Res #25 had a quarterly MDS dated [DATE]. A quarterly MDS, dated [DATE], was not signed as completed until 12/02/23. 4. Res #26 had an annual MDS dated [DATE]. A quarterly MDS, dated [DATE], was not signed as completed until 12/02/23. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Res #40 had an admission MDS dated [DATE]. A quarterly MDS, dated [DATE], was not signed as completed until 12/02/23. 7. Res #42 had a quarterly MDS dated [DATE]. A quarterly MDS, dated [DATE], was not signed as completed until 12/02/23. On 12/05/23 at 11:45 a.m., MDS coordinator #1 stated quarterly MDS assessments must be signed as completed within two weeks of the assessment reference date of the MDS. The coordinator acknowledged the assessments for the above residents were completed later than the required three month frequency. They stated they were unsure how the assessments were missed. 47751 8. Res #35's quarterly resident assessment was due on 11/10/23 and the status of the assessment was late. On 12/05/23 at 10:01 a.m., the MDS coordinator was asked if Res #35's quarterly assessment due 11/10/23 had been completed. They stated it has not been completed. They were asked should the quarterly assessment have been completed on 11/10/23. They stated yes it should have been.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 47751 Based on record review and interview, the facility failed to notify the state authority of a new mental health diagnoses for one (#25) of two sampled residents reviewed for PASRR's. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. Findings: A level I PASRR screen, dated 04/06/21, documented Res #25 was screened and a level I was completed. It was documented there were no indicators for a level II PASRR. On 06/21/2022, Res #25 received a new diagnosis of bipolar disorder. There was no documentation the state authority had been notified of the resident's new diagnoses to see if a level II PASRR was required. On 12/05/23 at 11:24 a.m., the MDS coordinator stated Res #25's level one PASRR documented no serious mental illness. They stated they should have notified the state authority of the new bipolar diagnosis.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 47751 Based on record review, interview, and observation the facility failed to ensure PEG tube feeding containers were properly labeled for one (#20) of one sampled resident observed with PEG tube feedings. The MDS coordinator identified three residents receiving PEG tube feedings. Findings: A facility policy, titled, Enteral Feedings-Safety Precautions policy, revised May 2014, read in parts, . Preventing errors in administration .2. On the formula label document initials, date and time the formula was hung/administered . Resident #20 had diagnoses which included cerebrovascular disease, gastrostomy status, abnormal weight loss, dysphagia, and vascular dementia. A physician's order, dated 05/19/23, documented to administer Jevity 1.5 at 50 ml/hr continuous via peg tube with 60 ml/hr continuous water. On 12/04/23 at 11:36 a.m., a container of Jevity 1.5 on a continuous pump running at 50 ml/hr was observed. There was no date, time, or nurse initials on the Jevity container. On 12/06/23 at 9:21 a.m., LPN #2 was asked what the facility policy was when hanging a new Jevity container. They stated they were supposed to date, time, and initial the Jevity bottle just prior to hanging. On 12/07/23 at 10:03 a.m., the DON was asked what their expectation was for the nursing staff when hanging a new Jevity container onto the continuous pump for Res #20. They stated the nursing staff should be dating, timing, and initialing the Jevity container just prior to hanging onto the pump.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 33148 Based on observation, record review, and interview, the facility failed to ensure physicians orders were followed for administering 02 for two (#5 and #15) of two sampled residents reviewed for respiratory care. The administrator identified nine residents who received O2. Findings: 1. Res #5 had diagnoses which included congested heart failure. A physician order, dated 03/17/23, documented O2 via nasal cannula at 2 LPM to maintain O2 saturation above 89 percent twice a day PRN. On 12/04/23 at 1:00 p.m., the resident was observed with O2, but the prongs of the nasal cannula were not in their nostrils. The O2 setting on the concentrator was 4 1/2 to 5 LPM. On 12/05/23 at 11:55 a.m., the resident was observed with O2 in place. The O2 setting on the concentrator was 3 LPM. 2. Res #15 had diagnoses which included COPD. A physician order, dated 01/03/23, documented O2 at 2 LPM via nasal cannula to keep O2 saturation above 89 percent. On 12/04/23 at 12:39 p.m., the resident was observed with O2 in place. The O2 setting on the concentrator was 3 LPM. On 12/05/23 at 11:23 a.m., the resident was observed with O2 in place. The O2 setting on the concentrator was 3 LPM. On 12/05/23 at 12:01 p.m., LPN #1 was asked how many liters of O2 Res #5 and Res #15 was to receive. They stated 3 LPM. They were asked to verify what the physicians orders documented the residents were to have received. They stated 2 LPM. They were asked to verify how many LPM the residents were receiving. They looked at the residents O2 concentrators and stated they were set at 3 LPM. They were made aware of the observations made on 12/04/23.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33148 Based on observation, record review, and interview, the facility failed to administer medications as ordered for one (#3) of six sampled residents reviewed for medications. The DON identified there were no residents who had physician orders to self administer medications. Findings: An Administering Medications policy, revised 12/2012, read in parts, .Medications shall be administered in a safe .manner, and as prescribed .Medications must be administered in accordnace with the orders . Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely . Res #3 had diagnoses which included COPD. A physician order, dated 03/15/23, documented ipratropium albuterol (bronchodilator) solution for nebulization 0.5 mg-3 mg (2.5 mg base)/3 ml one vial four times a day. On 12/05/23 at 3:12 p.m., the resident was observed seated on the side of their bed with a nebulizer mask covering their nose and mouth. Medication was observed being filtered through the mask. There was no staff present in their room or at their door. On 12/05/23 at 3:22 p.m., LPN #1 was observed going into the resident's room and the breathing treatment was shut off. On 12/05/23 at 3:24 p.m., LPN #1 was asked if the resident had orders to to self administer medications. They stated they did not. They were asked what was the protocol when a resident received a breathing treatment. They stated they did not know, but had heard staff were supposed to stay with the resident while the treatment was being administered. They were asked they were present while the resident received their breathing treatment. They stated they were not.

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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. 33148 Based on record review and interview, the facility failed to ensure the physician responded to pharmacist DRRs for one (#27) of five sampled residents reviewed for unnecessary medications. The administrator identified 45 residents resided in the facility. Findings: Resident #27 had diagnoses which included overactive bladder. A DRR, dated 06/06/23, documented the pharmacist made a recommendation to reduce ditropan (antimuscarinic medication) from TID to BID. There was no documentation the physician reviewed and responded to the recommendation. A DRR, dated 09/06/23, documented the pharmacist made a recommendation to reduce ditropan from TID to BID. There was no documentation the physician responded to the recommendation. On 12/06/23 at 12:39 p.m., the DON was asked was shown the DRRs for June and September 2023. They were asked to locate documentation the physician had responded to the recommendations. They stated they would not have a response to the June DRR. On 12/06/23 at 2:08 p.m., the DON stated they did not have documentation the physician responded to the DRRs. They stated the physician should have received the pharmacist's recommendation within one week and responded within two days.

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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. 33148 Based on observation, record review and interview, the facility failed to ensure: a. PRN psychotropic medications were limited to 14 days for two (#15 and #39), b. side effect monitoring was conducted for the use of psychotropic medications for one (#27), and c. unnecessary psychotropic medications were not administered for one (#27) of six sampled residents reviewed for medications. The administrator identified 39 residents who had orders for routine psychotpice medications and seven residents who had orders for PRN psychotropic medications. Findings: 1. Res #15 had diagnoses which included anxiety. A physician order, dated 11/04/23, documented lorazepam (antianxiety medication) 2 mg/ml. Give 0.25 ml by mouth every four hours PRN. There was no documentation the medication was limited to 14 days or a rationale to extend the medication. The November and December 2023 MARs were reviewed. It was documented lorazepam was administered one out of one opportunity beyond the 14 day limit. 2. Res #39 had diagnoses which included unspecified dementia with agitation. A physician order, dated 11/08/22, documented lorazepam 0.5 mg tablet PRN. There was no documentation the medication was limited to 14 days or a rationale to extend the medication, The September through December 2023 MARs were reviewed. It was documented lorazepam was administered two out of two opportunities beyond the 14 day limit. On 12/05/23 at 10:20 a.m., the DON was asked what was the protocol for the use of PRN psychotropic medications. They stated they were limited to 14 days. They were made aware Res #15 and Res #39 were administered lorazepam beyond the 14 day limit. 3. Res #27 had diagnoses which included depression, insomnia, anxiety, and abnormal weight loss. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 07/27/22, documented trazadone (antidepressant medication) 50 mg tablet at bedtime. A physician order, dated 06/18/23, documented venlafaxine 75 mg two capsules once a day. A MRR, dated 07/10/23, documented the pharmacist recommenced trazadone be reduced from 50 mg to 25 mg. The physician agreed to the recommendation and the recommendation was noted by the facility on 07/18/23. A physician order, dated 07/18/23, documented trazadone 50 mg. Give half tablet to equal 25 mg at bedtime. A care plan, dated 08/01/23, documented the resident received antidepressant medications. It documented to assess and record effectiveness of drug treatment. It documented to monitor and report signs of sedation, hypotension, or anticholinergic symptoms. A physician order, dated 08/02/23, documented mirtazapine (antidepressant medication) 15 mg at bedtime. The July through December 2023 MARs were reviewed. It was documented lorazepam 50 mg and lorazepam 25 mg had been administered at bedtime since 07/18/23. There was no documentation the physician order for the 50 mg tablet of lorazepam ordered on 07/27/22 had been discontinued per the pharmacy recommendation. There was no documentation side effects were being monitored for the use of antidepressant medications. There were no observations of the resident being over sedated during the survey. On 12/06/23 at 10:50 a.m., the DON was asked if the resident was being monitored for the use of antidepressant medications. They reviewed the resident's EHR and stated they did not see where they were being monitored for side effects. On 12/06/23 at 2:35 p.m., CMA #3 was asked about the administration of the resident's trazadone. They reviewed the resident's orders and stated they had orders for a total of 75 mg of trazadone. On 12/06/23 at 2:47 p.m., the DON was made aware the pharmacist made a recommendation to reduce the resident's trazadone from 50 mg to 25 mg in July 2023 and the physician agreed. They were made aware the order for trazadone 50 mg was not discontinued and the resident had been receiving trazadone 75 mg at bedtime since 07/18/23.

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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 less than 5%. A total of 25 opportunities were observed with three errors. The total medication error rate was 12.0%. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. Findings: Res #29's physician order, dated 12/04/23, documented to administer florastor 250 mg by mouth twice daily for abnormal weight loss. On 12/06/23 at 8:48 a.m. CMA #1 asked LPN #2 if they were supposed to administer the florastor. LPN #2 stated no because it was the same med as the lactinex. On 12/06/23 at 8:55 a.m., CMA #1 was observed during medication pass to crush and administer enteric coated ferrous sulfate 325 mg tablet and a potassium chloride tablet ER 10 meq. On 12/06/23 at 9:12 a.m., CMA #1 was asked if they administered any medications that should not be crushed according to the standards of practice. They stated the potassium chloride tablet ER. On 12/06/23 at 9:17 a.m. LPN #2 was asked to review the resident's MAR and to communicate any medications that should not be crushed according to the standards of practice. They stated yes, the ferrous sulfate and the potassium chloride tablet ER should not be crushed. They were made aware CMA #1 crushed and administered the enteric coated ferrous sulfate 325 mg tablet and the potassium chloride tablet ER 10 meq. They stated they would educate CMA #1 on medications that should not be crushed. On 12/06/23 at 10:12 a.m. the DON was made aware CMA #1 had crushed and administered an enteric coated ferrous sulfate 325 mg tablet and a potassium chloride tablet ER 10 meq and did not administer the florastor 250 mg. The DON stated the ferrous sulfate and potassium chloride ER should not have been crushed and that the florastor 250 mg should have been administered. They stated they would educate the nurses and CMA's on medications that are not to be crushed according to the standards of practice and to follow physician orders during medication pass.

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	375394	A. Building B. Wing	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoyah East Nursing Center, LLC	701 South Taylor Road Roland, OK 74954

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46387 Based on observation and interview, the facility failed to ensure refrigerated medications were stored in a manner to maintain the integrity of the medications and failed to dispose of expired medications. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. The administrator stated all 45 residents received medications. Findings: On 12/07/23 at 12:40 p.m., a tour of the medication room on hall 500 was conducted. A black mini-fridge was observed with a blue plastic storage container in the door of the refrigerator. The container was removed and ice was observed flaking from the bagged medication in the container. Upon lifting one of the medications from the container it was observed the medications were stuck together in approximately 1 inch of ice in the bottom of the container. There was approximately 1/2 inch of water remaining in the container when the ice was lifted. The medications extracted from the ice included 12 separate plastic bags containing bisacodyl suppositories, two of which had standing water in the bag with the medications. There was a cardboard box containing acetaminophen suppositories partially encased in the ice which fell apart upon removal from the ice. An additional bag containing acetaminophen suppositories was observed in the container. There was a medication bottle containing two vials of albumin with an expiration date of 12/2022. A bag containing a vial of a hepatitis B vaccine had an expiration date of 08/12/22. A bag containing two vials of the hepatitis B vaccine was observed with an expiration date of 08/11/23. On 12/07/23 at 12:42 p.m., the DON stated the medication room should be checked for expired medications at least monthly. They stated they were unsure how the medications in the refrigerator became frozen or how the water got into the container. On 12/07/23 at 12:52 p.m., the white mini-fridge was observed with a vial of influenza vaccine was open and undated. Two boxes of tuberculin test solution were observed opened and undated. A pre-filled insulin metered dose syringe was observed with an opened date of 09/25/23. On 12/07/23 at 12:55 p.m., an opened box of albuterol inhalant solution was observed with an expiration date of 11/28/23. An additional unopened box was observed with an expiration date of 11/2023. On 12/07/23 at 12:56 p.m., an open box of Ipratropium/albuterol solution was observed with an expiration date of 08/2023. On 12/07/23 at 1:03 p.m., the medication room on hall 300 was observed. A small white refrigerator was observed with an open bottle of Jevity feeding solution dated 11/01/23. An open undated vial of tuberculin test solution was observed with an expiration date of 04/22/23. The box containing the vial was observed to be wet and falling apart when touched. In a filing cabinet, a 16 F 30 cc foley catheter was observed with an expiration date of 10/26/17. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/07/23 at 1:06 p.m., CMA #1 stated the medication room was checked weekly for expired medications. They stated the tube feeding solution should only be kept for 24 hours.

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. 33148 Based on record review and interview, the facility failed to ensure labs were collected as ordered by the physician for one (#27) of five sampled residents reviewed for lab services. The administrator identified 45 resident resided in the facility. Findings: Res #27 had diagnoses which included type 2 diabetes mellitus, neuromuscular dysfunctional bladder, and unspecified viral hepatitis C. A physician order, dated 02/06/23, documented to collect a CBC, CMP, HbA1c, lipid panel, TSH in March, June, September, and December. It documented to collect an urine microalbumin annually in September. There was no documentation a CBC, CMP, HbA1c, lipid panel, and TSH were collected in March and September 2023. There was no documentation an urine microalbumin was collected in September 2023. On 12/06/23 at 12:39 p.m., the DON was asked to provide documentation the above labs were collected. On 12/06/23 at 2:08 p.m., the DON stated the labs were not collected.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 33148 Based on record review and interview, it was determined the facility failed to ensure a facility assessment was updated annually. The administrator identified 45 residents resided in the facility. Findings: On 12/04/23 at 10:39 a.m., an entrance conference was conducted with the administrator. They were made aware a facility assessment was required to be provided within four hours of entrance. There was no documentation a facility assessment had been updated annually. On 12/05/23 at 1:53 p.m., the administrator stated they did not have a facility assessment.

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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. 46387 Based on record review and interview, the facility failed to establish an infection surveillance program and failed to follow infection control practices during medication pass. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. Findings: A facility policy, titled, Administering Medications, revised December 2012, read in parts, .Policy Interpretation and Implementation .22. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications . 1. On 12/05/23 at 1:20 p.m. the infection control surveillance program documentation was requested. On 12/05/23 at 1:52 p.m., the administrator stated they did not have any documentation infections were being tracked or monitored. They stated they were unsure if an infection surveillance program was established in the facility. On 12/05/23 at 2:02 p.m., the administrator stated there was not an established program in the facility to track infections or monitor residents for possible communicable diseases or infections to prevent spread within the facility. 47751 2. On 12/06/23 at 8:53 a.m., CMA #1 was observed to be wearing gloves and preparing medications for administration. While wearing the gloves, they were observed to touch the pill crusher, medication cart drawers, medication cart keys, a container of pudding, the laptop screen, and a blood pressure cuff. On 12/06/23 at 9:08 a.m., CMA # 1 was observed to administered the medications, then they walked out of Resident #29's room and took off and discarded their gloves. They were asked what they should have done during their medication administration process. They stated I should have changed gloves. On 12/06/23 at 10:19 a.m., the DON was made aware CMA #1 did not change gloves between preparing and administering medications to Resident #29. They stated the CMA should have changed their gloves between preparing and administering the medications.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 46387 Based on record review and interview, the facility failed to establish an antibiotic stewardship program. A Long-Term Care Facility Application for Medicare and Medicaid, dated 12/05/23, documented 45 residents resided in the facility. Findings: 1. On 12/05/23 at 1:20 p.m. the antibiotic stewardship program documentation was requested. On 12/05/23 at 1:52 p.m., the administrator stated they did not have any documentation of antibiotic stewardship. They stated they were unsure if an antibiotic stewardship program was established in the facility. On 12/05/23 at 2:02 p.m., the administrator stated there were not established protocols or a system to monitor antibiotic use.