STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425320	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare - North Augusta	350 Austin Graybill North Augusta, SC 29841

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50085 Based on observation, interview, record review, and review of facility policies, the facility failed to ensure the environment remained free from potential accident hazards for 4 of 5 residents, related to medications at bedside. Specifically, the facility failed to ensure the environment for Resident (R)33, R389, R38, and R69, was free of medication that was required to be properly monitored and stored, to prevent accidental hazards. Findings include: Review of the facility policy, revised 01/01/2019, titled, Medication Storage in the Facility policy states, Medications and biologicals are stored safely, securely and properly manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Under Procedures, B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medication are permitted to access medication. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. Review of the facility policy, revised 01/01/2019, titled, Preparation and General Guidelines: Self-Administration of Medications policy revealed under procedures, A. If the resident desires to self-administer medications, an assessment is conducted by a member of the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry our responsibility. E. Beside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, resident who self-administer. Review of R33's Face Sheet revealed R33 was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia, Alzheimer's disease late onset, emphysema, left anterior fascicular block, right bundle-branch block, atherosclerosis of aorta, hypertension, Hypothyroidism, Alzheimer's disease, major depressive disorder, recurrent, mild, generalized anxiety disorder, and adult failure to thrive. Review of R33's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R33 has no cognitive impairment. Section E revealed R33 has no rejection of care behavior exhibited. Section GG revealed R33 requires no assistance with activities of daily life, notes that R33 is independent to feed self. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R33's medical record did not reveal evidence that an assessment was completed for self-administration of medication. Review of R33's Physician Orders revealed an active order for, 9AM administration of Cyanocobalamin (Vitamin B-12) 1000mcg, Quetiapine 25mg 1 tablet, Thera-M 19mg Iron 400mcg 1 tablet, Tylenol Extra Strength 500mg 1 po tablet, and Verapamil 180mg 1 tablet listed for nursing medication administration. Nurse signed off for administration on 10/15/24. No evidence of active orders for self-administration. Review of R33's Care Plan, last revised on 08/05/24, revealed R33's medication and treatment orders are considered part of the active care plan. Goal: R33 will not have any negative outcomes from medications and treatments. Approach administer medications and treatments as ordered. Cognition/Communication Deficits related to dementia with fluctuating cognition and inability to always stay on topic. BCRS (Brief Cognitive Rating Scale) score of 21/35 and GDS (Global Deterioration Scale) score of 4.2/7 indicating a moderate cognitive impairment per ST assessment on 09/08/23. Review of R389's Face Sheet revealed R389 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's Disease with late onset, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, pulmonary hypertension, unspecified, hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure, atrial fibrillation, hypothyroidism, peripheral vascular disease, polyosteoarthritis and contracture. Review of R389's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/01/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R389 has intact cognition. Further review of the MDS revealed R389 has no rejection of care behavior exhibited and is dependent to maximal assist of care. R389, with set up, is able to feed self, perform oral hygiene, and perform other personal hygiene task. Review of R389's medical record did not reveal evidence that an assessment was completed for self-administration of medication. Review of R389's Physician Orders did not reveal an order for topical medication Nystatin Powder. Review of R389's Care Plan, last revised on 08/08/24, reveals R389's medication and treatment orders are considered part of the active care plan. Goal: R389 will not have any negative outcomes from medications or treatments. Approach administer medication and treatments as ordered. Review of R38's Face Sheet revealed R38 was admitted to the facility on [DATE], with diagnoses including but not limited to: Bipolar Disorder, anxiety disorder, insomnia, hypothyroidism, radiculopathy cervical region, polyneuropathy, polyosteoarthritis, and atherosclerotic heart disease. Review of R38's Quarterly MDS with an ARD of 09/30/24, revealed a BIMS score of 14 out of 15, indicating R38 has intact cognition. Section E revealed R38 has no rejection of care behavior exhibited. Section GG revealed R38 is dependent to maximal assist of care. R38, with set up, is able to feed self, perform oral hygiene, and perform other personal hygiene task. Review of R38's medical record did not reveal evidence that an assessment was completed for self-administration of medication. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R38's Physician Order did not reveal an order for Nervive Roll on cream. Review of R38's Care Plan, with a revision date of 10/13/24, revealed R38's medication and treatment orders are considered part of the active care plan. Goal: R389 will not have any negative outcomes from medications or treatments. Approach: administer medication and treatments as ordered. Problem: Cognitive loss/dementia, goal is R38 will communicate simple needs for 90 days until next review and update. Approach is to offer cues and reminders as needed. Remind R38 of surroundings only if it calms patient and visit for conversation stimulation. R38's problem of behavioral symptoms by observed occasional declination of medications and care. Diagnosis of bipolar disorder, these behaviors fluctuate related to diagnosis extremely pleasant at times and just as quickly she is accusatory and yelling. Review of R69's Face Sheet revealed R69 was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia, Alzheimer's disease, major depressive disorder, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, atherosclerotic heart disease, left bundle block, benign prostatic hyperplasia, and unqualified visual loss right eye. Review of R69's medical record did not reveal evidence that an assessment was completed for self-administration of medication. Review of R69's Physician Orders revealed an active order for, Wixela Inhub (Fluticasone propion-salmeterol) blister with device 250-50 mcg/dose, amount one puff inhalation twice a day listed for nursing medication administration. Review of R69's Care Plan reveals R69's identified problem is cognitive loss/dementia. Cognition fluctuate, requires assistance with decision making. Requires cues and reminders for safety. Brief Cognitive Rating Scale, BCRS of 26/35 and GDS (Global Deterioration Scale) score of 5.2/7 indicating moderately severe cognitive impairment per speech therapy assessment on 12/13/23. Resident continues with liberal unassisted ambulation about facility; cognitive deficits with dx; risk harm from his peers related to occasional socially intrusive during his interactions as he strolls and some peer's inability to interpret his interactions; episodes of agitation and verbal aggression occur as well related to his deficits edited on 09/10/24. Review of R69's Quarterly MDS with an ARD of 09/03/24, revealed a BIMS score of 10 out of 15, indicating R69 has moderate cognitive impairment. Section E revealed R69 has no rejection of care behavior exhibited. Section GG revealed R69 is independent in activities of daily life and feeding self. During an observation and interview on 10/15/24 at 10:51 AM, of R33's room, a medication cup with several pills where on the bedside table in front of R33. There were no staff present and R33's roommate was in a wheelchair leaving the restroom. During introductions, R33 quickly took the medications in the cup without the nurse present. R33 stated, she does not know the medicine she takes but takes what the nurse places on the table in the cup for her to take. R33 revealed that staff occasionally leave her medicines in her room for her to take by herself because she is able. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/15/24 at 10:54 AM, Licensed Practical Nurse (LPN)2 signed off administration of R33's 9:00 AM medications, which included: Cyanocobalamin (Vitamin B-12) 1000mcg, Quetiapine 25mg 1 tablet, Thera-M 19mg Iron 400mcg 1 tablet, Tylenol Extra Strength 500mg 1 po tablet, and Verapamil 180mb 1 tablet. LPN2 stated R33 can give herself the medication unattended because she is independent, and she knows her medications. LPN2 further stated, R33 is sometimes given her medications like this and has not had any issues in the past. LPN2 confirmed that R33 does not have an order to self-administer medications and acknowledged the facility policy for self-administration. During an observation on 10/15/24 at 12:41 PM, of R38's room, revealed a Nervive roll on 2.5oz 8/2025 Lot 4092Y5 and IcyHot Max Lidocaine lot 24B401 02/2026, was located on the bedside table in front of R38. Furthermore, there was one unopened box of Nervive 7/2025 Lot 4030Y5 box medication cream 3.0oz on the bookshelf. During an observation and interview on 10/16/24 at 10:36 AM, the Director of Nursing (DON) verified the Nystatin powder lot421209 3/31/2026, on R389's dresser. The DON stated that treatment medications should be secured on the cart unless it is peri care and lotion. If there is a prescription, there should be a bedside order. During an observation on 10/16/24 at 10:53 AM, of R69's room, revealed an inhalation medication on the tall dresser next to the television. The inhalar was left opened and unattended. Further review of the inhaler revealed, Fluticasone Propionate and Salmeterol 250mcg/50mcg 60 blisters with lot number AC2029A expiration date of MAR2026, 43 puffs left. No open date and no use by date on the medication. During an interview on 10/16/24 at 10:56 AM, Licensed Practical Nurse (LPN)2 verified the medication on the dresser in R69's room and stated that another LPN forgot it earlier after administration of medication due to cleaning R69's room. LPN2 further stated she watched R69 take medication and receive breathing treatment at 8:08 AM that morning. LPN2 than closed the medication and secured medication back in in cart. During an interview on 10/16/24 at 04:02 PM the (ADON) Assistant Director of Nursing/Infection Control revealed that she was not aware of the items being in the room and ADON was following up with R38 and seen the medication at bedside. ADON took the Nervive roll that was on the bedside table and three bottles of the Nervive R38 had in the bedside drawer. ADON reported that she educated the resident and left with the items. Expectations are for staff to follow policy and if items are coming from family educate the resident and let them know why they cannot have at bedside. We are to keep in the medication cart and regulate it for R38 and keep it locked up for patient safety. Expectation for self-administration is that we do have a protocol to follow to determine if they are competent to do to self-administer. During an interview on 10/16/24 at 04:15 PM the ADON revealed the expectation to follow policy that medication should be administered at bedside and watched. The ADON stated, we can assess their competency level to see if they can self-administer but there is a protocol. I do not know the specifics because i have not heard of it being done often and i have been here three years. R33 has not been assessed for self-administration. We train the nurses on medication administration and documentation annually and frequently at nurse's meetings probably 3 to 4 times a year. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 11:31 AM, the Administrator revealed that every patient is within eyesight of nurse and at bedside when taking medications. The Administrator stated, If the patient is able to self-administer the patient needs to be assessed and care planned appropriately. I am aware of two patients in this facility that is approved for self-administration. During an interview on 10/17/24 at 11:39 AM, the Administrator revealed that administration medications should be locked and if not the patient need to be cleared to self-administer. The barrier cream for peri-care is allowed but anything that is coming from the pharmacy should be properly assessed and screened for self-administration. Daily rounding by leadership is done to ensure there is not an incident or hazard and to assist staff. If there is an issue we are to address, educate. The way that we address family are at different intervals at admission and it states what they can and cannot provide. We explain to the family that we oversee care and if anything is needed, we can provide. We also address as it is an issue, we address it seasonally (especially Christmas), resident council, and at care plans. Based on observation, interview, record review, and review of facility policies, the facility failed to ensure the environment remained free from potential accident hazards for 4 of 5 residents, related to medications at bedside. Specifically, the facility failed to ensure the environment for Resident (R)33, R389, R38, and R69, was free of medication that was required to be properly monitored and stored, to prevent accidental hazards. Findings include: Review of the facility policy, revised 01/01/2019, titled, Medication Storage in the Facility policy states, Medications and biologicals are stored safely, securely and properly manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Under Procedures, B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medication are permitted to access medication. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. Review of the facility policy, revised 01/01/2019, titled, Preparation and General Guidelines: Self-Administration of Medications policy revealed under procedures, A. If the resident desires to self-administer medications, an assessment is conducted by a member of the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry our responsibility. E. Beside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, resident who self-administer. Review of R33's Face Sheet revealed R33 was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia, Alzheimer's disease late onset, emphysema, left anterior fascicular block, right bundle-branch block, atherosclerosis of aorta, hypertension, Hypothyroidism, Alzheimer's disease, major depressive disorder, recurrent, mild, generalized anxiety disorder, and adult failure to thrive. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R33's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R33 has no cognitive impairment. Section E revealed R33 has no rejection of care behavior exhibited. Section GG revealed R33 requires no assistance with activities of daily life, notes that R33 is independent to feed self. Review of R33's medical record did not reveal evidence that an assessment was completed for self-administration of medication. Review of R33's Physician Orders revealed an active order for, 9AM administration of Cyanocobalamin (Vitamin B-12) 1000mcg, Quetiapine 25mg 1 tablet, Thera-M 19mg Iron 400mcg 1 tablet, Tylenol Extra Strength 500mg 1 po tablet, and Verapamil 180mg 1 tablet listed for nursing medication administration. Nurse signed off for administration on 10/15/24. No evidence of active orders for self-administration. Review of R33's Care Plan, last revised on 08/05/24, revealed R33's medication and treatment orders are considered part of the active care plan. Goal: R33 will not have any negative outcomes from medications and treatments. Approach administer medications and treatments as ordered. Cognition/Communication Deficits related to dementia with fluctuating cognition and inability to always stay on topic. BCRS (Brief Cognitive Rating Scale) score of 21/35 and GDS (Global Deterioration Scale) score of 4.2/7 indicating a moderate cognitive impairment per ST assessment on 09/08/23. Review of R389's Face Sheet revealed R389 was admitted to the facility on [DATE], with diagnoses including but not limited to: Alzheimer's Disease with late onset, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, pulmonary hypertension, unspecified, hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure, atrial fibrillation, hypothyroidism, peripheral vascular disease, polyosteoarthritis and contracture. Review of R389's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/01/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R389 has intact cognition. Further review of the MDS revealed R389 has no rejection of care behavior exhibited and is dependent to maximal assist of care. R389, with set up, is able to feed self, perform oral hygiene, and perform other personal hygiene task. Review of R389's medical record did not reveal evidence that an assessment was completed for self-administration of medication. Review of R389's Physician Orders did not reveal an order for topical medication Nystatin Powder. Review of R389's Care Plan, last revised on 08/08/24, reveals R389's medication and treatment orders are considered part of the active care plan. Goal: R389 will not have any negative outcomes from medications or treatments. Approach administer medication and treatments as ordered. Review of R38's Face Sheet revealed R38 was admitted to the facility on [DATE], with diagnoses including but not limited to: Bipolar Disorder, anxiety disorder, insomnia, hypothyroidism, radiculopathy cervical region, polyneuropathy, polyosteoarthritis, and atherosclerotic heart disease. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R38's Quarterly MDS with an ARD of 09/30/24, revealed a BIMS score of 14 out of 15, indicating R38 has intact cognition. Section E revealed R38 has no rejection of care behavior exhibited. Section GG revealed R38 is dependent to maximal assist of care. R38, with set up, is able to feed self, perform oral hygiene, and perform other personal hygiene task. Review of R38's medical record did not reveal evidence that an assessment was completed for self-administration of medication. Review of R38's Physician Order did not reveal an order for Nervive Roll on cream. Review of R38's Care Plan, with a revision date of 10/13/24, revealed R38's medication and treatment orders are considered part of the active care plan. Goal: R389 will not have any negative outcomes from medications or treatments. Approach: administer medication and treatments as ordered. Problem: Cognitive loss/dementia, goal is R38 will communicate simple needs for 90 days until next review and update. Approach is to offer cues and reminders as needed. Remind R38 of surroundings only if it calms patient and visit for conversation stimulation. R38's problem of behavioral symptoms by observed occasional declination of medications and care. Diagnosis of bipolar disorder, these behaviors fluctuate related to diagnosis extremely pleasant at times and just as quickly she is accusatory and yelling. Review of R69's Face Sheet revealed R69 was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia, Alzheimer's disease, major depressive disorder, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, atherosclerotic heart disease, left bundle block, benign prostatic hyperplasia, and unqualified visual loss right eye. Review of R69's medical record did not reveal evidence that an assessment was completed for self-administration of medication. Review of R69's Physician Orders revealed an active order for, Wixela Inhub (Fluticasone propion-salmeterol) blister with device 250-50 mcg/dose, amount one puff inhalation twice a day listed for nursing medication administration. Review of R69's Care Plan reveals R69's identified problem is cognitive loss/dementia. Cognition fluctuate, requires assistance with decision making. Requires cues and reminders for safety. Brief Cognitive Rating Scale, BCRS of 26/35 and GDS (Global Deterioration Scale) score of 5.2/7 indicating moderately severe cognitive impairment per speech therapy assessment on 12/13/23. Resident continues with liberal unassisted ambulation about facility; cognitive deficits with dx; risk harm from his peers related to occasional socially intrusive during his interactions as he strolls and some peer's inability to interpret his interactions; episodes of agitation and verbal aggression occur as well related to his deficits edited on 09/10/24. Review of R69's Quarterly MDS with an ARD of 09/03/24, revealed a BIMS score of 10 out of 15, indicating R69 has moderate cognitive impairment. Section E revealed R69 has no rejection of care behavior exhibited. Section GG revealed R69 is independent in activities of daily life and feeding self. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/15/24 at 10:51 AM, of R33's room, a medication cup with several pills where on the bedside table in front of R33. There were no staff present and R33's roommate was in a wheelchair leaving the restroom. During introductions, R33 quickly took the medications in the cup without the nurse present. R33 stated, she does not know the medicine she takes but takes what the nurse places on the table in the cup for her to take. R33 revealed that staff occasionally leave her medicines in her room for her to take by herself because she is able. During an observation and interview on 10/15/24 at 10:54 AM, Licensed Practical Nurse (LPN)2 signed off administration of R33's 9:00 AM medications, which included: Cyanocobalamin (Vitamin B-12) 1000mcg, Quetiapine 25mg 1 tablet, Thera-M 19mg Iron 400mcg 1 tablet, Tylenol Extra Strength 500mg 1 po tablet, and Verapamil 180mb 1 tablet. LPN2 stated R33 can give herself the medication unattended because she is independent, and she knows her medications. LPN2 further stated, R33 is sometimes given her medications like this and has not had any issues in the past. LPN2 confirmed that R33 does not have an order to self-administer medications and acknowledged the facility policy for self-administration. During an observation on 10/15/24 at 12:41 PM, of R38's room, revealed a Nervive roll on 2.5oz 8/2025 Lot 4092Y5 and IcyHot Max Lidocaine lot 24B401 02/2026, was located on the bedside table in front of R38. Furthermore, there was one unopened box of Nervive 7/2025 Lot 4030Y5 box medication cream 3.0oz on the bookshelf. During an observation and interview on 10/16/24 at 10:36 AM, the Director of Nursing (DON) verified the Nystatin powder lot421209 3/31/2026, on R389's dresser. The DON stated that treatment medications should be secured on the cart unless it is peri care and lotion. If there is a prescription, there should be a bedside order. During an observation on 10/16/24 at 10:53 AM, of R69's room, revealed an inhalation medication on the tall dresser next to the television. The inhalar was left opened and unattended. Further review of the inhaler revealed, Fluticasone Propionate and Salmeterol 250mcg/50mcg 60 blisters with lot number AC2029A expiration date of MAR2026, 43 puffs left. No open date and no use by date on the medication. During an interview on 10/16/24 at 10:56 AM, Licensed Practical Nurse (LPN)2 verified the medication on the dresser in R69's room and stated that another LPN forgot it earlier after administration of medication due to cleaning R69's room. LPN2 further stated she watched R69 take medication and receive breathing treatment at 8:08 AM that morning. LPN2 than closed the medication and secured medication back in in cart. During an interview on 10/16/24 at 04:02 PM the (ADON) Assistant Director of Nursing/Infection Control revealed that she was not aware of the items being in the room and ADON was following up with R38 and seen the medication at bedside. ADON took the Nervive roll that was on the bedside table and three bottles of the Nervive R38 had in the bedside drawer. ADON reported that she educated the resident and left with the items. Expectations are for staff to follow policy and if items are coming from family educate the resident and let them know why they cannot have at bedside. We are to keep in the medication cart and regulate it for R38 and keep it locked up for patient safety. Expectation for self-administration is that we do have a protocol to follow to determine if they are competent to do to self-administer. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/24 at 04:15 PM the ADON revealed the expectation to follow policy that medication should be administered at bedside and watched. The ADON stated, we can assess their competency level to see if they can self-administer but there is a protocol. I do not know the specifics because i have not heard of it being done often and i have been here three years. R33 has not been assessed for self-administration. We train the nurses on medication administration and documentation annually and frequently at nurse's meetings probably 3 to 4 times a year. During an interview on 10/17/24 at 11:31 AM, the Administrator revealed that every patient is within eyesight of nurse and at bedside when taking medications. The Administrator stated, If the patient is able to self-administer the patient needs to be assessed and care planned appropriately. I am aware of two patients in this facility that is approved for self-administration. During an interview on 10/17/24 at 11:39 AM, the Administrator revealed that administration medications should be locked and if not the patient need to be cleared to self-administer. The barrier cream for peri-care is allowed but anything that is coming from the pharmacy should be properly assessed and screened for self-administration. Daily rounding by leadership is done to ensure there is not an incident or hazard and to assist staff. If there is an issue we are to address, educate. The way that we address family are at different intervals at admission and it states what they can and cannot provide. We explain to the family that we oversee care and if anything is needed, we can provide. We also address as it is an issue, we address it seasonally (especially Christmas), resident council, and at care plans.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50085 Based on observation, interview, record review, and policy review, the facility failed to provide respiratory care in accordance with professional standards. Specifically, the facility failed to ensure the nebulizer machines mask for Resident (R)69 and R389 were clean, labelled, and bagged when not in use. Findings include: Review of the policy titled Jet Nebulizer Treatment revised 09/07 reveals under procedure,10. When treatment is completed remove the nbulizer to the sink area, empty any remaining medication, rinse with water, and return setup to bag. Note change nebulizer setups weekly, date and initial equipment. Review of Review of Resident 69's face sheet revealed that resident was current admitted to the facility on [DATE] with the diagnoses listed but not limited to dementia, Alzheimer's disease, major depressive disorder, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, atherosclerotic heart disease, left bundle block, benign prostatic hyperplasia, and unqualified visual loss right eye. Review of Resident 389's face sheet revealed that resident was current admitted to the facility on [DATE] with the diagnoses listed but not limited to Alzheimer's Disease with late onset, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, pulmonary hypertension, unspecified, hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure, atrial fibrillation, hypothyroidism, peripheral vascular disease, polyosteoarthritis and contracture. Review of R69's Physician Orders revealed orders for Budesonide Suspension for nebulization 0.5mg/2mL give twice a day. Review of R69's care plan revealed that R69 identified problem is Respiratory, at risk for complications related to Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, personal history of nicotine dependence, and shortness of breath. Approach administer nebulizer, inhaler as indicated. Review of R69's Minimum Data Set (MDS) quarterly review dated 09/03/2024 revealed a Brief Interview for Mental Status (BIMS) score is 10 out of 15, R 69 has moderate cognitive impairment. Section E revealed R63 has no rejection of care behavior exhibited. Section GG revealed R69 is independent in activities of daily life and feeding self. Review of R389's Physician Orders revealed orders for Albuterol Sulfate Solution for nebulization 2.5mg/3mL (0.083%) one nebulizer three times a day. Review of R389's care plan revealed that R389 is not care planned for breathing treatments scheduled or PRN. Last revised care plan with start date 09/16/2024 problem listed acute bronchitis with approaches medications and lab per orders, resident will complete antibiotics on 09/18/2024. Observe for increased signs and symptoms of infection, and vital signs as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R389's annual MDS dated [DATE] revealed a BIMS score is 13 out of 15, R389 has intact cognition. Section E revealed R389 has no rejection of care behavior exhibited. Section GG revealed R389 is dependent to maximal assist of care. R389, with set up, is able to feed self, perform oral hygiene, and perform other personal hygiene task. During an observation and interview of R69 on 10/15/24 at 01:27 PM resident was fully dressed ambulatory in room. The face mask with connected tubing to the jet nebulizer machine was not dated, not in a bag, and located on the right side of the nightstand near floor. R69 revealed having a breathing treatment that morning. During an observation of R389's room on 10/15/24 at 12:15 PM, there was a face mask with connected tubing to the jet nebulizer machine not dated, not in a bag, located on the floor between the bed and nightstand. During an observation of R389's room on 10/16/24 at 10:29 AM, there was a face mask with connected tubing to the jet nebulizer machine not dated, not in a bag, located on the floor between the bed and nightstand. During an observation and interview on 10/16/24 at 10:39 AM, the Director of Nursing (DON) witnessed R389's jet nebulizer's face mask on the floor and revealed that the respiratory equipment is expected to be in a bag and dated. She stated, I am sure staff has had in-service on respiratory care and infection control. DON immediately discarded mask. DON revealed that respiratory therapy is in charge of weekly changes of respiratory equipment. The nurses are in charge of daily care. During an interview on 10/16/24 at 10:56 AM, Licensed Practical Nurse (LPN)2 revealed that she gave the jet nebulizer treatment and the inhaler that morning at 8:08 AM. She revealed that after treatment, she rinsed R69's face mask but, she left it across the bed. LPN2 was aware of the policy when it is not in use it is to be stored in a plastic bag to keep the dust and keep it clean. The bags are labeled treatments. During an interview on 10/16/24 at 03:52 PM, the DON revealed that staff are trained on respiratory equipment on hire and as needed for trends. The equipment or mask is expected to be rinsed after usage, set on a paper towel to dry and placed in a dated bag. The DON stated, It is expected to be changed weekly. It is my expectation that nurses are following policy as it pertains to medication administration and respiratory care. During an interview on 10/16/24 at 04:37 PM, the Assistant Director of Nursing revealed the policy for the nebulizer are expected to be followed. The nebulizer mask are to be rinsed out and bagged. The plan of correction we will reeducate staff on the proper storage of the respiratory equipment. During an interview on 10/17/24 at 11:50 AM the Administrator revealed an expectation is that the nebulizer is stored in a bag and labeled. It is expected to be rinsed, dried, dated, and packed in place. We must assure that it is being done by rounding and addressing that it is being done.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50085 Based on the facility policy titled, Specific Medication Administration Procedures IIB1: Administration Procedures for All Medications, observations and interviews, the facility failed to ensure Resident (R)95 was free from significant medication errors. Specifically, ertapenem reconstituted solution 1 gram infused with 100mL of normal saline intravenous (IV) in a safe manner and in accordance with professional standards of medication administration via peripherally inserted central catheter (PICC or PICC line). The findings include: Review of the facility policy titled, Specific Medication Administration Procedures IIB1: Administration Procedures for All Medications, states under the Policy Statement, To administer medications in a safe and effective manner. An observation on 10/17/2024 at 1:08 PM revealed ertapenem intravenous administration for R95. Licensed Practical Nurse (LPN)1 failed to ensure R95 safely received antibiotic therapy via PICC line by improperly managing the IV line once primed to reduce the risk of contamination before going to the patient. The primed uncapped IV line was placed on a blue chux and then the outside of an alcohol packet, then administered to the R95. LPN1 when accessing PICC line failed to scrub/wipe top of access for a minimum of 15 seconds. Task completed less than 10sceonds and uncapped IV line was placed within access. LPN1 started infusion. During an interview on 10/17/24 at 01:46 PM the Director of Nursing revealed that skills training is done once a year. This training included PICC lines and IV infusions. The expectation is that staff follow protocol and follow infection control guidelines during medication administration. The last class was in November 2023 and that was the skill fair. Since this morning, we have started retaining the licensed practical nurses regarding the PICC and working with R95. We have another skills fair that is in November 2024. During an interview on 10/17/24 at 02:09 PM, LPN1 revealed that she does not remember her last PICC Training. LPN1 revealed that she was expected to use a clean technique when accessing a PICC line. She admitted to taking the uncapped primed IV line, placing on the blue pad, and once alerted placed the uncapped IV line on an alcohol pack. LPN1 revealed that she was expected to discard of the IV line and start over prior to administering to R95. Review of Competency Standard Skills Checklist for PICC lines with LPN name, signature, and not dated with DON name, signature, and date of 11/21/23.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50085 Based on review of facility policy, record review, observation and interview the facility failed to provide 1 of 4 residents (R95) and 1 of 34 medication opportunities given by 4 nurses, medication administration without possibility of cross contamination. Specifically, ertapenem reconstituted solution 1 gram infused with 100mL of normal saline intravenous in accordance with infection control and prevention standards of medication administration via peripherally inserted central catheter (PICC or PICC line). Findings include: Review of the facility policy titled, Specific Medication Administration Procedures IIB1: Administration Procedures for All Medications, states under the Policy Statement, To administer medications in a safe and effective manner. Review of the facility policy titled, PICC and Midline Catheter Flushing, states under general guideline, 3. Consult state Nurse Practice Act for RN/LPN scope of practice and function. Review of Competency standard skills checklist PICC lines with DON name, signature, and date of 11/21/23. LPN1 name and signature present without a date. Checklist revealed flushing the PICC line, administer infusion, changing the PICC line, and changing the PICC adapter instructions that have been checked off by LPN1 except for changing the PICC line. Under flushing the PICC line, Scrub the top of the adapter of the PICC with alcohol swab for minimum 15 seconds with a juicing action. Under Administer Infusion, 3. Thoroughly friction swab access site with alcohol for 15 seconds. Review of R95's face sheet revealed R95 was admitted to the facility on [DATE] with diagnoses including, but not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region, Escherichia coli, extended spectrum beta lactamase, proteus, enterococcus as the cause of disease and presence of cardiac or vascular implant and graft, PICC line. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R95 had a Brief Interview of Mental Status (BIMS) score of 2, suggesting R95 is severely cognitively impaired. It further revealed R95 does not exhibit behavior of rejection of care. Review of R95's physician orders revealed R95 has an ongoing ertapenem reconstituted solution 1 gram infused with 100mL of normal saline intravenous for one hour vis PICC line every 24 hours start date 09/18/2024 to end date 10/18/2024. An observation on 10/17/2024 at 1:08 PM revealed ertapenem intravenous administration for R95. Licensed Practical Nurse (LPN)1 failed to ensure R95 safely received antibiotic therapy via PICC line by improperly managing the intravenous (IV) line once primed to reduce the risk of contamination before going to the patient. The primed uncapped IV line was placed on a blue chux and then the outside of an alcohol packet, then administered to the R95. LPN1 when accessing PICC line failed to scrub/wipe top of access for a minimum of 15 seconds. Task completed less than 10sceonds and uncapped IV line was placed within access. LPN1 started infusion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 1:46 PM, the Director of Nursing revealed that skills training is done once a year. She stated, this training included PICC lines and IV infusions. The expectation is that staff follow protocol and follow infection control guidelines during medication administration. The last class was in November 2023 and that was the skills fair. Since this morning, we have started retaining the licensed practical nurses regarding the PICC and working with R95. We have another skills fair that is in November 2024. During an interview on 10/17/24 at 1:51 PM, the Assistant Director of Nursing/Infection Preventionist revealed that the staff are expected to follow procedures for sterile and clean technique per policy when it is warranted. During an interview on 10/17/24 at 2:09 PM, LPN1 revealed that she does not remember her last PICC Training. She revealed that she was expected to use a clean technique with accessing a PICC line. LPN1 confirmed taking the uncapped primed IV line, placing on the blue pad, and once alerted placed the uncapped IV line on an alcohol pack. LPN1 revealed that she was expected to discard of IV line and start over prior to administering to R95.