STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445254	A. Building B. Wing	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oneida Nursing and Rehab Center	18805 Alberta Dr Oneida, TN 37841

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on medical record review and interview, the facility failed to refer 1 resident (Resident #3) of 4 residents reviewed for Pre-Admission Screening and Resident Review (PASRR), to the state-designated authority for a Level II PASRR after the resident was identified with possible serious mental disorder diagnosis. The findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses including Depressive Disorder, Anxiety Disorder, Unspecified Dementia and Atherosclerotic Heart Disease. A diagnosis of Psychosis was added on 4/14/2022. Review of a Level I PASRR dated 12/17/2021 showed diagnoses of Dementia, Anxiety and Depression, and a Level II PASRR was not required. Record review showed a diagnosis of Psychotic Disorder was identified on 4/14/2022 and added to the resident's list of diagnoses. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #3 had severely impaired cognitive skills. The resident had verbal behaviors directed towards others on 1-3 days of the 7 day look back period. During an interview on 9/18/2023 at 2:14 PM, Social Services Coordinator #1 stated the PASRR Level I dated 12/17/2021 was the only PASRR on Resident #3's chart. She stated if a new mental health diagnosis was added, a new PASRR should be submitted to the state designated authority. She confirmed a new PASRR for a level II evaluation had not been submitted after a new mental health diagnosis of Psychosis was added on 4/14/2023.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40639 45837 Based on facility policy review, record review, observation, and interview, the facility failed to develop a comprehensive care plan to meet the person-centered dementia care needs for 2 residents (Resident #3 and #29), and activities of daily living (ADL) care needs for 1 resident (Resident #33) of 16 residents reviewed for care plans. The findings include: Review of the facility's undated policy titled, Care Plans-Comprehensive, showed .individualized comprehensive care plan that includes .objectives .to meet the resident's .needs is developed for each resident .Care plans are revised as changes .dictate .Residents, their families .are invited to attend .care planning conferences .Changes .must be reported to the MDS Coordinator .care plan can be made . Resident #3 was admitted to the facility on [DATE] with diagnoses including Depressive Disorder, Anxiety Disorder, Unspecified Dementia and Atherosclerotic Heart Disease. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #3 had severe cognitive impairment and required extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had verbal behaviors directed towards others on 1-3 days of the 7 day look back period, and there was no rejection of care behaviors noted. During an interview on 9/17/2023 at 11:29 AM, Licensed Practical Nurse (LPN) #1 stated the staff reviewed the resident's care plan to obtain individualized care information for each resident. Record review showed an individualized care plan for Resident #3 had not been developed or implemented related to the resident's Dementia care needs. Resident #29 was admitted to the facility on [DATE] with diagnoses including Dementia, Type II Diabetes and Hyperlipemia. Review of a quarterly MDS assessment dated [DATE] showed Resident #29 had severe cognitive impairment. Record review showed an individualized care plan for Resident #3 had not been developed or implemented related to the resident's Dementia care needs. Resident #33 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Pneumonia and Hyperkalemia. Review of a quarterly MDS assessment dated [DATE] showed Resident #33 had severe cognitive impairment and required total dependence of 2 staff for bed mobility, toilet use and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 9/18/2023 at 9:58 AM, in Resident #33's room, showed the resident's beard was unkempt. During an interview on 9/18/2023 at 3:20 PM, Certified Nursing Assistant (CNA) #1 stated Resident #33's daughter did not want staff to shave him. During a telephone interview on 9/19/2023 at 12:10 PM, the MDS Coordinator confirmed with Resident #33's daughter that she did not wish for staff to shave his beard. The MDS Coordinator stated nursing staff had not reported the specific ADL preference to her. During an interview on 9/19/2023 at 12:14 PM, the MDS Coordinator stated Resident #3 had a diagnosis of Dementia with Behavioral Disturbance and Dementia with Agitation, and Resident #29 had a diagnosis of Dementia. She stated she would expect the residents to have care plans for dementia and the ADLs would be updated on the care plan to reflect the family's wishes. The MDS Coordinator confirmed Residents #3 and #29 had no care plan for dementia, and Resident #33 had no personalized care plan for ADLs regarding his beard.

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40639 Based on facility policy review, professional standards review, medical record review, observation and interview, the facility failed to provide services which met professional standards of practice when a Registered Nurse (RN) #1 failed to administer essential medications, including anti-hypertensives, cardiac medications, and insulin, as ordered by the resident's physician, and failed to notify the physician when the essential medications had been withheld for 3 residents (Resident #3, #13, and #22) of 7 residents reviewed for medication administration. The facility's failure had the potential to create negative adverse outcomes to Residents #3, #13 and #22 and had the potential to affect all residents of the facility. The facility's failure created an immediate jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, impairment, or death to a resident). The Immediate Jeopardy (IJ) of F658 was cited at a scope and severity of K and was effective 8/12/2023-9/21/2023. The Administrator was informed of the Immediate Jeopardy on 9/21/2023 at 11:27 AM. An Acceptable Allegation of Compliance was received on 9/21/2023 and verified on site on 9/22/2023. F658 remains at a scope and severity of E, and the facility is required to submit a Plan of Correction. The findings include: Review of the facility's policy titled, Adverse Consequences and Medication Errors, revised 4/2014, showed . A medication error is defined as the preparation or administration of drugs and biological which is not in accordance with physician's orders .or accepted professional standards . Review of the accepted standard used by the facility titled, Medication Administration: NCLEX [National Council Licensure Examination]-RN, dated 9/2023, showed .Nurses are legally and ethically responsible and accountable for accurate and complete .documentation .All medications that are .held or refused by the patient must be documented in .medication record in addition to other data like vital signs .as indicated by . the doctor's order . Resident #3 was admitted to the facility on [DATE] with diagnoses including Depressive Disorder, Unspecified Dementia, Chronic Pain Syndrome, Impulse Disorder, Heart Failure, Mood Disorder, Insomnia, Personal History of Transient Ischemic Attack (TIA), Psychosis, and Paroxysmal Atrial Fibrillation (an irregular heartbeat). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #3 had severe cognitive impairment and required limited assistance of 1 staff member for eating. On the 7-day look back, antipsychotic medications, anticoagulant medications and antidepressant medications were given on 7 days, and the resident had no swallowing disorders. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's physician's orders with dates showed the following: Depakote (a medication used to treat mood disorder) Extended Release (ER) 500 milligram (mg, a unit of measure), daily at bedtime (HS), dated 2/11/2022, Mirtazapine (a medication used to treat Depression) 7.5 mg, give 1 tablet HS, dated 3/14/2022, Seroquel (a medication used to treat Psychosis and Depression) 200 mg, give 1 tablet HS, dated 4/14/2022, Carvedilol (a medication used to treat Heart Failure) 3.125 mg, give 1 tablet twice daily (BID), hold and notify physician if blood pressure (BP) is less than 90/60 or pulse is less than 60, dated 12/22/2021, Acetaminophen (a medication used to treat pain) 500 mg, give 2 tablets to equal 1000 mg BID, dated 4/4/2022. Docusate Sodium (a medication used to treat occasional constipation) 100 mg, give 1 tablet BID, dated 12/8/2022 and Eliquis (a medication that thins the blood) 2.5 mg, give 1 tablet BID, dated 4/23/2022. Review of a psychiatry follow up note, for Resident #3, dated 8/4/2023 showed, .Follow up regarding mood disorder, insomnia .Staff deny any recnet [recent] psychosis .Cognition remains at baseline .Staff report mood remains stable .Sleep remains stable with Mirtazapine 7.5mg .[Resident #3] appeared to be calm and not in distress . Also, the current medications of Depakote 500 mg HS, Mirtazapine 7.5 mg HS, Seroquel 200 mg HS were reviewed by the psychiatric provider. Gradual dose reduction (GDR) comments stated, . Continued use of current psychotropic medication(s) is in accordance with the current standards of practice. It is my assessment that a GDR is contraindicated at this time as target symptoms are unstable . this [resident] is at high risk for decompensation if a GDR were attempted . Review of Resident #3's Medication Administration Record (MAR) dated 8/2023 showed the medication of Depakote ER 500 mg BID, Mirtazapine 7.5 mg HS, Seroquel 200 mg HS, Docusate Sodium 100 mg BID, Carvedilol 3.125 mg BID, Acetaminophen 500 mg BID and Eliquis 2.5 mg BID had not been administered as ordered by the physician on 8/12/2023 at 9:00 PM by RN #1. The vital signs documented for 8/12/2023 were a BP of 124/64, Pulse 80 and was within the parameters for the administration for the anti-hypertensives. It was documented that Resident #3 had no pain at 7:00 AM, 3:00 PM and 11:00PM. On 8/13/2023, the vital signs documented were BP 127/70, Pulse 76 and no pain at 7:00 AM, 3:00 PM and 11:00PM which showed no adverse changes in the vital signs related to the omission of the medications. There was no rationale documented on the omission of the ordered medications by RN #1or that RN #1 had notified the physician after the medications had been withheld. During a telephone interview on 9/19/2023 at 4:36 PM, RN #1 confirmed he had worked on 8/12/2023 and had not administered the 9:00 PM doses of Depakote ER 500 mg, Mirtazapine 7.5 mg, Seroquel 200 mg, Docusate Sodium 100 mg, Carvedilol 3.125 mg, Acetaminophen 500 mg and Eliquis 2.5 mg on 8/12/2023 to Resident #3 according to the physician's orders and had failed to notify the physician when the medications had been withheld. Continued interview revealed RN #1 had not documented a rationale as to why the medications had not been administered and was unable to provide an explanation during the interview. Resident #13 was admitted to the facility 8/25/2023 with diagnoses including End Stage Renal Disease, Acute on Chronic Diastolic Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia, Dementia, Pulmonary Edema, Hyperlipidemia, Asthma, Anxiety, Hypertension, Chronic Obstructive Pulmonary Disease, and Type 2 Diabetes Mellitus. Review of the admission MDS assessment dated [DATE], showed Resident #13 had moderate cognitive impairment. Resident #13 received insulin injections on 3 of the 7 days of the look back period and the resident received dialysis services. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #13's physician's orders with dates showed the following: Lisinopril (a medication used to treat high blood pressure) 40 mg by mouth daily. It was noted .CHECK BP AND PULSE BEFORE ADMIN [administration]., IF BP BELOW 90/60 OR PULSE BELOW 60, HOLD AND NOTIFY MD [medical doctor] . dated 8/27/2023. Carvedilol 25 mg by mouth twice daily. It was noted .CHECK BP AND PULSE BEFORE ADMIN., IF BP BELOW 90/60 OR PULSE BELOW 60 HOLD AND NOTIFY MD . dated 8/27/2023. Clonidine (a medication used to treat high blood pressure) 0.2 mg by mouth three times daily for Hypertension. It was noted .CHECK BP AND PULSE BEFORE ADMIN, IF BP BELOW 90/60 OR PULSE BELOW 60 HOLD AND NOTIFY MD . dated 8/27/2023. Amlodipine Besylate (a medication used to treat high blood pressure) 10 mg by mouth daily, with note .CHECK BP AND PULSE BEFORE ADMIN., IF BP BELOW 90/60 OR PULSE BELOW 60, HOLD AND NOTIFY MD . dated 8/27/2023. Hydralazine (a medication used to treat high blood pressure) 50 mg was noted to give 2 tablets by mouth three times daily, and it was noted .PRIOR TO ADMIN CHECK BP AND PULSE IF BP IS LESS THAN 90/60 OR PULSE IS LESS THAN 60 HOLD AND NOTIFY MD . dated 8/28/2023. Insulin Lispro (a medication that lowers the level of sugar in the blood) 100 units/milliliter (ml) showed, .Give sliding scale subcutaneously as follows per sliding scale: [for a measured blood glucose of the following values, give the dictated amount of insulin] 0-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 10 units, 351-400 = 12 units. If 400 and above give 14 units and notify md . dated 8/28/2023 and discontinued on 9/7/2023, and .Notify MD of blood glucose less than or equal to 60 or greater than 400, follow MD orders. Hold all insulin if blood glucose less than 100 . dated 8/28/2023. Glimepiride (a medication used to treat Diabetes) 1 mg by mouth twice daily, showed .HOLD FOR BLOOD GLUCOSE LESS THAN 70 . dated 9/1/2023 and discontinued on 9/8/2023. Lantus Solostar (a medication used to treat Diabetes) 100 unit/ml was noted to give 8 units subcutaneously every night and hold if the resident's blood glucose was less than 100 dated 9/8/2023. During observation and interview on 9/19/2023 at 3:35 PM, of Resident #13's MAR dated 9/2023 with RN #1, showed the following: 9/1/2023 a BP of 124/72 and Pulse of 76. 9/3/2023 a BP of 122/70 and Pulse of 76. 9/4/2023 a BP of 119/68 and Pulse of 67. 9/5/2023 a BP and Pulse had not been documented. 9/9/2023 a BP of 116/72 and Pulse of 74. Continued review showed Lisinopril 40 mg- 1 tablet by mouth had not been administered on 9/1/2023, 9/3/2023, 9/4/2023, 9/5/2023 and 9/9/2023. The 9:00 PM dose of Carvedilol 25 mg had not been administered on 9/1/2023, 9/4/2023, 9/5/2023 and 9/9/2023. The 9:00 PM dose of Clonidine 0.2 mg had not been administered on 9/1/2023, 9/5/2023, and 9/9/2023 and the 9:00 PM dose of Hydralazine 50 mg had not been administered on 9/1/2023, 9/4/2023, and 9/9/2023. The MAR showed the documented BP's and pulses were within the parameters noted in the physician's orders for the administration of the anti-hypertensive and cardiac medications. Glimepiride 1 mg had not been administered on 9/1/2023 (blood glucose 112), 9/2/2023 (blood glucose 106), 9/3/2023 (blood glucose 167), 9/4/2023 (blood glucose 84), and 9/5/2023 (blood glucose 110). (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Insulin Lispro 100 unit/ml pen, 4:30 PM dose had not been administered on 9/3/2023 (blood glucose 167), and the resident should have received 2 units; the 9:00 PM dose had not been administered on 9/5/2023 (blood glucose 246), and the resident should have received 4 units; the 4:30 PM dose had not been administered on 9/6/2023 (blood sugar 315), and the resident should have received 10 units; the 9:00 PM dose had not been administered on 9/6/2023 (blood glucose 173), and the resident should have received 2 units. The Lantus Solostar 100 units/ml. Give 8 units subcutaneously every night, had not been administered on 9/9/2023 (blood glucose 340), 9/13/2023 (blood glucose 198), and 9/14/2023 (blood glucose 187). RN #1 confirmed the medication had not been administered as ordered by the physician and had failed to notify the physician when the medications had been withheld. Resident #22 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including End Stage Renal Disease, Anemia, Heart Failure, and Hypertension. Review of a quarterly MDS assessment dated [DATE] showed Resident #22 was cognitively intact, required supervision with eating and had received 7 days of injections of insulin, 7 days of antianxiety medications, 7 days of antidepressant medications and 6 days of opioids during the 7-day look back period. Continued review showed the resident received dialysis services. Review of Resident #22's physician's orders and dates showed the following: Metoprolol Tartrate (a medication used to treat high blood pressure and Atrial Fibrillation) 50 mg tablet give 1 tablet by mouth twice daily. Hold if BP less than 90/60 or Pulse below 60 and notify Medial Doctor (MD) dated 5/25/2023. Hydralazine 25 mg tablet give 1 tablet by mouth twice daily. Hold if BP is less than or equal to 90/60 or Pulse is less than 60 dated 7/13/2023. Review of Resident #22's MAR dated 9/2023 showed the following: 9/4/2023 at 6:00 PM, a BP of 118/69 and Pulse of 72 9/6/2023 at 6:00 PM, a BP of 122/71 and Pulse of 65. 9/9/2023 at 6:00 PM, a BP of 133/62 and Pulse of 62. 9/10/2023 at 6:00 PM, a BP of 158/76 and Pulse of 68. The 6:00 PM dose of Metoprolol Tartrate 50 mg had not been administered on 9/4/2023, 9/6/2023, 9/9/2023, and 9/10/2023. The 6:00 PM dose of Hydralazine 25 mg had not been administered on 9/4/2023, 9/6/2023, and 9/10/2023. The MAR showed N (not given) in the initial box with RN #1's initials for those days. Continued review showed no documented rationale as to why the medications had been withheld. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/19/2023 at 2:29 PM, RN #1 confirmed the medications for Residents #3, #13 and #22 had not been administered as ordered by the physician. RN #1 further confirmed he was aware the physician's orders, and the BP, pulse, and blood glucose were within the designated parameters for the medications to be administered. The RN stated he had not administered the BP medications or the insulin because he was afraid the resident's blood pressure and blood sugar would drop to low. RN #1 stated he was aware of the procedure to document a rationale when a medication was not administered and to notify the physician. RN #1 also confirmed he had failed to notify the physician when he withheld the essential medications for Residents #3, #13, and #22. RN #1 also confirmed he had failed to document a rationale for the omission of the medications. During an interview on 9/20/2023 at 4:37 PM, the Administrator and DON stated it was their expectation that the physician was notified when a medication was not administered and that medications were administered according to the physician's orders. The DON confirmed RN #1 had failed to administer essential medications as ordered for Residents #3, #13 and #22, failed to document the rationale for the omitted medications, and had failed to notify the physician when the medications had been withheld. Continued interview with the DON confirmed RN #1 had not followed the facility's policy on medication administration and had not met the professional standards of practice for medication administration. During a telephone interview on 9/20/2023 at 8:51 AM, the Medical Director revealed it was her expectation the prescribed orders were to be followed as written with the parameters set for BP, pulse, and blood glucose levels and to be notified when the medications had not been administered. The Medical Director further stated it was her expectation when a medication was withheld a rationale was to be documented in the residents' medical records. On 9/19/2023, the Medical Director stated she had not been made aware the medications for Residents #3, #13, and #22 had not been administered as ordered until after it had been identified by the State Agency. The Medical Director stated Resident #13's long term glycemic control was maintained with the insulin and Glimepiride, and no immediate harm was noted. However, not maintaining the blood glucose undermines the glycemic control. She stated Residents #3, #13 and #22 had not suffered any complications or had required medical interventions after the medications had been withheld. On 9/22/2023, Surveyors reviewed the education sign in sheets and new audit forms implemented which validated the corrective action plans onsite. Surveyors reviewed the Quality Assurance and Performance Improvement (QAPI) meeting sign-in sheet and interviewed QAPI members regarding the ad-hoc meeting that occurred on 9/19/2023 which discussed the implementation of the medication pass audit and the Medication Administration Record (MAR) audit. Attendees of the ad-hoc QAPI meeting included Minimum Data Set (MDS) Coordinator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Director of Operations, and the Administrator. Surveyors verified onsite the implementation of the medication pass audit and Medication Administration Record (MAR) audits. Surveyors reviewed medication pass audits, interviewed staff, and reviewed education sign in sheets for education provided that included medication error and medication hold procedure. Surveyors verified that 100% of facility nurses had received the education by reviewing education sign in sheets and interviewing staff present in the facility. Surveyors reviewed the MAR audits for all in house residents and the daily audit form of non-administered medications to be completed 5 days per week by the DON, ADON, or MDS Coordinator. Registered Nurse (RN) #1 was suspended by the facility on 9/19/2023 and terminated on 9/21/2023.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40639 Based on facility policy review, medical record review, and interview the facility failed to ensure essential medications were administered as ordered by the physician and failed to notify the physician when the medications had been withheld, which had the potential to alter therapeutic drug levels and create negative adverse outcomes for 3 residents (Resident #3, #13, and #22) of 7 residents sampled for medication administration. The facility's failure placed Resident #3, Resident #13, Resident #22 in immediate jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, impairment, or death to a resident) and had the potential to affect all residents of the facility. The Immediate Jeopardy (IJ) of F684 was cited at a scope and severity of K and was effective 8/12/2023-9/21/2023. The Administrator was informed of the Immediate Jeopardy on 9/21/2023 at 11:27 AM. An Acceptable Allegation of Compliance was received on 9/21/2023 and verified on site on 9/22/2023. F684 remains at a scope and severity of E and the facility is required to submit a Plan of Correction. The findings include: Review of the facility's policy titled, Adverse Consequences and Medication Errors, revised 4/2014, .A medication error is defined as the preparation or administration of drugs and biological which is not in accordance with physician's orders .or accepted professional standards .Examples of medication errors include: omission-a drug is ordered but not administered .The attending physician is notified of any medication error . Resident #3 was admitted to the facility on [DATE] with diagnoses including Depressive Disorder, Unspecified Dementia, Chronic Pain Syndrome, Impulse Disorder, Heart Failure, Mood Disorder, Insomnia, Personal History of Transient Ischemic Attack (TIA), Psychosis, and Paroxysmal Atrial Fibrillation (an irregular heartbeat which returns to normal within 7 days). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #3 had severe cognitive impairment and required limited assistance with eating. Received 7 days of antipsychotic, anticoagulant, and antidepressant medications for the 7-day look back period. Review of Resident #3's physician's orders with dates showed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Depakote (a medication used to treat mood disorder) Extended Release (ER) 500 milligram (mg) at bedtime (HS), dated 2/11/2022. Mirtazapine (a medication used to treat Depression) 7.5 mg at HS, dated 3/14/2022, Seroquel (a medication used to treat bipolar disorder, psychosis and depression) 200 mg at HS, dated 4/14/2022, Carvedilol (a medication used to treat Heart Failure) 3.125 mg, give 1 tablet twice daily (BID), hold and notify physician if blood pressure (BP) is less than 90/60 or Pulse is less than 60, dated 12/22/2021, Acetaminophen (a medication used to treat pain) 500 mg, give 2 tablets to equal 1000 mg BID, dated 4/4/2022, Docusate Sodium (a medication used to treat occasional constipation) 100 mg, give 1 tablet BID, dated 12/8/2022, and Eliquis (a medication used to treat Atrial Fibrillation) 2.5 mg, give 1 tablet BID, dated 4/23/2022. Review of a Medication Administration Record (MAR) dated 8/2023, showed the medications for Resident #3 for Depakote ER 500 mg, BID, Mirtazapine 7.5 mg HS, Seroquel 200 mg HS, Docusate Sodium 100 mg BID, Carvedilol 3.125 mg BID, Acetaminophen 500 mg BID and Eliquis 2.5 mg BID had not been administered as ordered on 8/12/2023 at 9 PM by RN #1. The vital signs documented for 8/12/2023 were a BP of 124/64, Pulse 80 and no pain at 7:00 AM, 3:00 PM and 11:00 PM. On 8/13/2023, the documented vital signs were BP 127/70, Pulse 76 and no pain at 7:00 AM, 3:00 PM and 11:00PM. There was no documentation stating why the medications were held or that the RN had notified the physician. Resident #13 was admitted to the facility 8/25/2023 with diagnoses including End Stage Renal Disease, Acute on Chronic Diastolic Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia, Dementia, Pulmonary Edema, Hyperlipidemia, Asthma, Anxiety, Hypertension, Chronic Obstructive Pulmonary Disease, and Type 2 Diabetes Mellitus. Review of the admission MDS assessment dated [DATE], showed Resident #13 had moderate cognitive impairment. Resident #13 received insulin injections on 3 of the 7 days of the look back period. Continued review showed the resident received dialysis services. Review of Resident #13's physician's orders with dates showed the following: Lisinopril (a medication used to treat high blood pressure) 40 mg by mouth daily. It was noted .CHECK BP AND PULSE BEFORE ADMIN [administration] .IF BP BELOW 90/60 OR PULSE BELOW 60, HOLD AND NOTIFY MD [medical doctor] . dated 8/27/2023. Carvedilol 25 mg by mouth twice daily.CHECK BP AND PULSE BEFORE ADMIN., IF BP BELOW 90/60 OR PULSE BELOW 60 HOLD AND NOTIFY MD . dated 8/27/2023, Clonidine (a medication used to treat high blood pressure) 0.2 mg by mouth three times daily .CHECK BP AND PULSE BEFORE ADMIN, IF BP BELOW 90/60 OR PULSE BELOW 60 HOLD AND NOTIFY MD . dated 8/27/2023, Amlodipine Besylate (a medication used to treat high blood pressure) 10 mg by mouth daily .CHECK BP AND PULSE BEFORE ADMIN., IF BP BELOW 90/60 OR PULSE BELOW 60, HOLD AND NOTIFY MD . dated 8/27/2023, Hydralazine (a medication used to treat high blood pressure) 50 mg give 2 tablets by mouth three times daily, .PRIOR TO ADMIN CHECK BP AND PULSE IF BP IS LESS THAN 90/60 OR PULSE IS LESS THAN 60 HOLD AND NOTIFY MD . dated 8/28/2023, Insulin Lispro (a medication used to treat Diabetes) 100 units/milliliter (ml) showed, .Give sliding scale subcutaneously as follows per sliding scale: [for a measured blood glucose of the following values, give the dictated amount of insulin] 0-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 10 units, 351-400 = 12 units. If 400 and above give 14 units and notify md . dated 8/28/2023 and was discontinued on 9/7/2023, .Notify MD of blood glucose less than or equal to 60 or greater than 400, follow MD orders. Hold all insulin if blood glucose less than 100 . dated 8/28/2023, Glimepiride (a medication used to treat Diabetes) 1 mg by mouth twice daily, showed .HOLD FOR BLOOD GLUCOSE LESS THAN 70 . dated 9/1/2023 and was discontinued on 9/8/2023, and for the Lantus Solostar (a medication to treat Diabetes) 100 unit/ml give 8 units subcutaneously every night and hold if the resident's blood glucose if less than 100 dated 9/8/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oneida Nursing and Rehab Center	18805 Alberta Dr Oneida, TN 37841

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation of Resident #13's MAR dated 9/2023 and interview with RN #1 on 9/19/2023 at 3:35 PM, showed the following: 9/1/2023 a BP of 124/72 and Pulse of 76 9/3/2023 a BP of 122/70 and Pulse of 76 9/4/2023 a BP of 119/68 and Pulse of 67 9/5/2023 a BP or Pulse was not documented 9/9/2023 a BP of 116/72 and Pulse of 74 Lisinopril 40 mg- 1 tablet by mouth had not been administered on 9/1/2023, 9/3/2023, 9/4/2023, 9/5/2023 and 9/9/2023. The 9:00 PM dose of Carvedilol 25 mg had not been administered on 9/1/2023, 9/4/2023, 9/5/2023 and 9/9/2023. The 9:00 PM doses of Clonidine 0.2 mg had not been administered on 9/1/2023, 9/5/2023, and 9/9/2023 The 9:00 PM dose of Hydralazine 50 milligrams had not been administered on 9/1/2023, 9/4/2023, and 9/9/2023. The MAR showed the documented BP's and pulses were within the designated parameters for the medication administration as ordered by the physician. Glimepiride 1 mg had not been administered on 9/1/2023 (blood glucose 112), 9/2/2023 (blood glucose 106), 9/3/2023 (blood glucose 167), 9/4/2023 (blood glucose 84), and 9/5/2023 (blood glucose 110). Insulin Lispro 100 unit/ml pen, 4:30 PM dose had not been administered on 9/3/2023 (blood glucose 167), and the resident should have received 2 units; the 9:00 PM dose had not been administered on 9/5/2023 (blood glucose 246), and the resident should have received 4 units; the 4:30 PM dose had not been administered on 9/6/2023 (blood sugar 315), and the resident should have received 10 units; the 9:00 PM dose had not been administered on 9/6/2023 (blood glucose 173), and the resident should have received 2 units. The Lantus Solostar 100 units/ml. Give 8 units subcutaneously every night and had not been administered on 9/9/2023 (blood glucose 340), 9/13/2023 (blood glucose 198), and 9/14/2023 (blood glucose 187). RN #1 confirmed the medications had not been administered as ordered. Resident #22 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including End Stage Renal Disease, Anemia, Heart Failure, and Hypertension. Review of a quarterly MDS assessment dated [DATE] showed Resident #22 was cognitively intact, required supervision with eating, and had received 7 days of injections of insulin, antianxiety and antidepressant medications, and 6 days of opioid medications during the 7- day look back period. Continued review showed the resident received dialysis services. Review of Resident #22's physician's orders with dates showed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Oneida Nursing and Rehab Center	18805 Alberta Dr Oneida, TN 37841

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Metoprolol Tartrate (a medication used to treat high Blood Pressure and Atrial Fibrillation) 50 mg tablet give 1 tablet by mouth twice daily. Hold if BP less than 90/60 or Pulse below 60 and notify MD dated 5/25/2023, Hydralazine 25 mg tablet give 1 tablet by mouth twice daily. Hold if BP is less than or equal to 90/60 or Pulse is less than 60 dated 7/13/2023. Review of Resident #22's MAR dated 9/2023 showed the following: 9/4/2023 at 6:00 PM a BP of 118/69 and Pulse of 72 9/6/2023 at 6:00 PM a BP of 122/71 and Pulse of 65 9/9/2023 at 6:00 PM a BP of 133/62 and Pulse of 62 9/10/2023 a BP of 158/76 and a Pulse of 68 The 6:00 Pm dose of Metoprolol Tartrate 50 mg not been administered on 9/4/2023, 9/6/2023, 9/9/2023, and 9/10/2023. Hydralazine 25 mg had not been administered on 9/4/2023, 9/6/2023, and on 9/10/2023. The documentation showed an N (not given) in the initial box with RN #1's initials. Continued review showed a rationale had not been documented when the medications had been withheld. During an interview on 9/19/2023 at 2:29 PM, RN #1 stated he was aware of the facility's policy to document a rationale when medications were not administered and to notify the physician if the ordered medications had been withheld. RN #1 confirmed the physician was not notified of the omitted medications, and the essential medications had not been administered to Residents #3, #13, and #22 as ordered by the physician on the listed dates. During an interview on 9/20/2023 at 4:37 PM, the Administrator and the DON stated it was their expectation that the physician was notified when a medication was not administered and that medications were administered as ordered by the physician. The DON confirmed the following medications had not been administered according to the physician's orders for the following residents and dates: Resident #3's Depakote, Mirtazapine, Seroquel, Docusate Sodium, Eliquis, Carvedilol and Acetaminophen on 8/12/2023. Resident #13's Lisinopril on 9/1/2023, 9/3/2023, 9/4/2023, 9/5/2023, and 9/9/2023, 9:00 PM dose of Carvedilol on 9/1/2023, 9/4/2023, 9/5/2023, and 9/9/2023, 9:00 PM dose of Clonidine on 9/1/2023, 9/5/2023, and 9/9/2023, 9:00 PM dose of Hydralazine on 9/1/2023, 9/4/2023, and 9/9/2023, 5:00 PM dose of Glimepiride on 9/1/2023, 9/2/2023, 9/3/2023, 9/4/2023, and 9/5/2023, 4:30 PM dose of sliding scale Lispro insulin on 9/3/2023 and 9/6/2023, 9:00 PM dose of sliding scale Lispro insulin on 9/5/2023 and 9/6/2023, 9:00 PM dose of Lantus insulin on 9/9/2023, 9/13/2023, and 9/14/2023. Resident #22's Metoprolol Tartrate on 9/4/2023, 9/6/2023, 9/9/2023 and 9/10/2023, and Hydralazine on 9/4/2023, 9/6/2023, and 9/10/2023. The DON confirmed RN #1 had not followed the facility's policy or professional standards of practice for medication administration and had not notified the physician of the medication omissions. However, the residents were placed at risk for harm by the omission of essential life sustaining medications. The DON and Administrator confirmed they had not been made aware of the medication omissions and did not have an effective auditing system to monitor for medication omissions. The DON and Administrator had not been made aware of any concerns related to medication administration until it was brought to their attention by the survey team on 9/19/2023. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 9/20/2023 at 8:51 AM, the Medical Director revealed she expected for the prescribed orders to be followed with the parameters set for the B/P, Pulse, and blood glucose. The Medical Director stated if medications were not administered as ordered, it was expected a rationale be documented for not administering the medication in the residents' medical records and she was to be notified of the omitted medications. The Medical Director stated before 9/19/2023, she had not been made aware the medications had not been administered as ordered for Residents #3, #13, and #22. The Medical Director further stated Resident #13's long term glycemic control was maintained with the use of insulin and Glimepiride medications. She also stated no immediate harm or serious adverse outcome was noted to Resident #13, but letting Blood Sugars go untreated undermined the glycemic control. The Medical Director stated she had not been made aware of any residents suffering any complications, and the residents had not required any new orders or medical interventions since the medications were omitted. On 9/22/2023, Surveyors reviewed the education sign in sheets and new audit forms implemented which validated the corrective action plans onsite. Surveyors reviewed the Quality Assurance and Performance Improvement (QAPI) meeting sign-in sheet and interviewed QAPI members regarding the ad-hoc meeting that occurred on 9/19/2023 which discussed the implementation of the medication pass audit and the Medication Administration Record (MAR) audit. Attendees of the ad-hoc QAPI meeting included Minimum Data Set (MDS) Coordinator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Director of Operations, and the Administrator. Surveyors verified onsite the implementation of the medication pass audit and Medication Administration Record (MAR) audits. Surveyors reviewed medication pass audits, interviewed staff, and reviewed education sign in sheets for education provided that included medication error and medication hold procedure. Surveyors verified that 100% of facility nurses had received the education by reviewing education sign in sheets and interviewing staff present in the facility. Surveyors reviewed the MAR audits for all in house residents and the daily audit form of non-administered medications to be completed 5 days per week by the DON, ADON, or MDS Coordinator. Registered Nurse (RN) #1 was suspended by the facility on 9/19/2023 and terminated on 9/21/2023.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40639 Based on facility policy review, medical record review, and interview, the facility failed to ensure 3 residents (Residents #3, #13, and #22) of 7 residents reviewed for Medication Administration were free of any significant medication errors when a Registered Nurse (RN) #1 failed to administer anti-hypertensives, cardiac medications, and insulin to the residents and failed to notify the physician after the essential medications had been omitted. The RN's failure to administer essential medications as ordered by the physician placed Residents #13 and #22 in immediate jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, impairment, or death to a resident) and had the potential to affect all residents in the facility. The Immediate Jeopardy (IJ) of F760 was cited at a scope and severity of K and was effective 8/12/2023-9/21/2023. The Administrator was informed of the Immediate Jeopardy on 9/21/2023 at 11:27 AM. An Acceptable Allegation of Compliance was received on 9/21/2023 and verified on site on 9/22/2023. F760 remains at a scope and severity of E and the facility is required to submit a Plan of Correction. The findings include: Review of the facility's policy titled, Adverse Consequences and Medication Errors, revised 4/2014, showed . A medication error is defined as the preparation or administration of drugs and biological which is not in accordance with physician's order .or accepted professional standards .Examples of medication errors include: omission-a drug is ordered but not administered .In the event of a significant medication-related error .immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: requiring medication discontinuation or dose modification (A current list of medications that should not be abruptly discontinued should be consulted before discontinuing a medication) .The attending physician is notified promptly of any significant error . Resident #3 was admitted to the facility on [DATE] with diagnoses including Depressive Disorder, Unspecified Dementia, Chronic Pain Syndrome, Impulse Disorder, Heart Failure, Mood Disorder, Insomnia, Personal History of Transient Ischemic Attack (TIA), Psychosis, and Paroxysmal Atrial Fibrillation (an irregular heartbeat). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident #3 had severe cognitive impairment and required limited assistance of 1 staff member for eating. On the 7-day look back, antipsychotic medications, anticoagulant medications and antidepressant medications were given on 7 days, and the resident had no swallowing disorders. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's physician's orders with dates showed the following: Depakote (a medication used to treat mood disorder) Extended Release (ER) 500 milligram (mg, a unit of measure), daily at bedtime (HS), dated 2/11/2022, Mirtazapine (a medication used to treat Depression) 7.5 mg, give 1 tablet HS, dated 3/14/2022, Seroquel (a medication used to treat Psychosis and Depression) 200 mg, give 1 tablet HS, dated 4/14/2022, Carvedilol (a medication used to treat Heart Failure) 3.125 mg, give 1 tablet twice daily (BID), hold and notify physician if blood pressure (BP) is less than 90/60 or pulse is less than 60, dated 12/22/2021, Acetaminophen (a medication used to treat pain) 500 mg, give 2 tablets to equal 1000 mg BID, dated 4/4/2022. Docusate Sodium (a medication used to treat occasional constipation) 100 mg, give 1 tablet BID, dated 12/8/2022 and Eliquis (a medication that thins the blood) 2.5 mg, give 1 tablet BID, dated 4/23/2022. Review of Resident #3's Medication Administration Record (MAR) dated 8/2023 showed the medication of Depakote ER 500 mg BID, Mirtazapine 7.5 mg HS, Seroquel 200 mg HS, Docusate Sodium 100 mg BID, Carvedilol 3.125 mg BID, Acetaminophen 500 mg BID and Eliquis 2.5 mg BID had not been administered by RN #1 as ordered by the physician on 8/12/2023 at 9:00 PM. The vital signs documented for 8/12/2023 were a BP of 124/64, Pulse 80 and was within the parameters for the administration for the anti-hypertensives. It was documented that Resident #3 had no pain at 7:00 AM, 3:00 PM and 11:00PM. On 8/13/2023, the vital signs documented were BP 127/70, Pulse 76 and no pain at 7:00 AM, 3:00 PM and 11:00PM which showed no adverse changes in the vital signs related to the omission of the medications. There was no rationale documented on the omission of the ordered medications by RN #1or that RN #1 had notified the physician after the medications had been withheld. Resident #13 was admitted to the facility 8/25/2023 with diagnoses including End Stage Renal Disease, Acute on Chronic Diastolic Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia, Dementia, Pulmonary Edema, Hyperlipidemia, Asthma, Anxiety, Hypertension, Chronic Obstructive Pulmonary Disease, and Type 2 Diabetes Mellitus. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #13 had moderate cognitive impairment. Resident #13 received insulin injections on 3 of the 7 days of the look back period. The resident received dialysis services. Review of Resident #13's Physician's Orders with dates showed the following: (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Lisinopril (a medication used to treat high blood pressure) 40 milligram (mg) by mouth daily .CHECK BP AND PULSE BEFORE ADMIN [administration] .IF BP BELOW 90/60 OR PULSE BELOW 60, HOLD AND NOTIFY MD [medical doctor] . dated 8/27/2023, Carvedilol (a medication used to treat high blood pressure) 25 mg by mouth twice daily .CHECK BP AND PULSE BEFORE ADMIN .IF BP BELOW 90/60 OR PULSE BELOW 60 HOLD AND NOTIFY MD . dated 8/27/2023, Clonidine (a medication used to treat high blood pressure) 0.2 mg by mouth three times daily for hypertension .CHECK BP AND PULSE BEFORE ADMIN, IF BP BELOW 90/60 OR PULSE BELOW 60 HOLD AND NOTIFY MD . dated 8/27/2023, Amlodipine Besylate (a medication used to treat high blood pressure) 10 mg by mouth daily .CHECK BP AND PULSE BEFORE ADMIN .IF BP BELOW 90/60 OR PULSE BELOW 60, HOLD AND NOTIFY MD . dated 8/27/2023, Hydralazine (a medication used to treat high blood pressure) 50 mg give 2 tablets by mouth three times daily, .PRIOR TO ADMIN CHECK BP AND PULSE IF BP IS LESS THAN 90/60 OR PULSE IS LESS THAN 60 HOLD AND NOTIFY MD . dated 8/28/2023, Insulin Lispro (a medication that lowers the level of sugar in the blood) 100 units/milliliter (ml) showed, .Give sliding scale subcutaneously as follows per sliding scale: [for a measured blood glucose of the following values, give the dictated amount of insulin] 0-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 10 units, 351-400 = 12 units. If 400 and above give 14 units and notify md . dated 8/28/2023 and discontinued on 9/7/2023 .Notify MD of blood glucose less than or equal to 60 or greater than 400, follow MD orders. Hold all insulin if blood glucose less than 100 . dated 8/28/2023, Glimepiride (a medication used to treat Diabetes) 1 mg by mouth twice daily, showed .HOLD FOR BLOOD GLUCOSE LESS THAN 70 . dated 9/1/2023 and discontinued on 9/8/2023, Lantus Solostar (a medication used to treat Diabetes) 100 unit/ml was noted to give 8 units subcutaneously (an injection under the skin) every night and hold if the resident's blood glucose was less than 100 dated 9/8/2023. During an observation and interview on 9/19/2023 at 3:35 PM, with RN #1 of Resident #13's MAR dated 9/2023, showed the following: 9/1/2023 a BP of 124/72 and Pulse of 76 9/3/2023 a BP of 122/70 and Pulse of 76 9/4/2023 a BP of 119/68 and Pulse of 67 9/5/2023 a BP and Pulse was not documented 9/9/2023 a BP of 116/72 and Pulse of 74 Lisinopril 40 mg- 1 tablet by mouth had not been administered on 9/1/2023, 9/3/2023, 9/4/2023, 9/5/2023 and 9/9/2023. The 9:00 PM dose of Carvedilol 25 mg had not been administered on 9/1/2023, 9/4/2023, 9/5/2023 and 9/9/2023. The 9:00 PM doses of Clonidine 0.2 mg had not been administered on 9/1/2023, 9/5/2023, and 9/9/2023 (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 9:00 PM dose of Hydralazine 50 milligrams had not been administered on 9/1/2023, 9/4/2023, and 9/9/2023. The MAR showed the documented BP and pulse were within the parameters noted in the physician's orders. The Glimepiride 1 mg had not been administered on 9/1/2023 (blood glucose 112), 9/2/2023 (blood glucose 106), 9/3/2023 (blood glucose 167), 9/4/2023 (blood glucose 84), and 9/5/2023 (blood glucose 110). The Insulin Lispro 100 unit/ml pen, 4:30 PM dose had not been administered on 9/3/2023 (blood glucose 167), and the resident should have received 2 units; the 9:00 PM dose had not been administered on 9/5/2023 (blood glucose 246), and the resident should have received 4 units; the 4:30 PM dose had not been administered on 9/6/2023 (blood sugar 315), and the resident should have received 10 units; the 9:00 PM dose had not been administered on 9/6/2023 (blood glucose 173), and the resident should have received 2 units. Lantus Solostar 100 units/ml, give 8 units subcutaneously every night, and had not been administered on 9/9/2023 (blood glucose 340), 9/13/2023 (blood glucose 198), and 9/14/2023 (blood glucose 187). The RN confirmed the medications had not been administered as ordered by the physician. Resident #22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Eng Stage Renal Disease, Anemia, Heart Failure, and Hypertension. Review of Resident #22's quarterly MDS assessment dated [DATE] showed resident was cognitively intact, required supervision with eating, and had received 7 days of insulin injections, 7 days of antianxiety medications, 7 days of antidepressant medications and 6 days of opioid medications during the 7 day look back period. Continued review showed the resident received dialysis services. Review of Resident #22's physician's orders with dates showed the following: Metoprolol Tartrate (a medication used to treat high blood pressure and Atrial Fibrillation) 50 mg tablet give 1 tablet by mouth twice daily. Hold if BP less than 90/60 or Pulse below 60 and notify MD dated 5/25/2023, Hydralazine 25 mg tablet give 1 tablet by mouth twice daily. Hold if BP is less than or equal to 90/60 or Pulse is less than 60 dated 7/13/2023. Review of Resident #22's MAR dated 9/2023 showed the following: 9/4/2023 at 6:00 PM a BP of 118/69 and a Pulse of 72. 9/6/2023 at 6:00 PM a BP of 122/71 and a Pulse of 65. 9/9/2023 at 6:00 PM a BP of 133/62 and a Pulse of 62. 9/10/2023 at 6:00 PM showed a BP of 158/76 and a Pulse of 68 The 6:00 PM dose of Metoprolol Tartrate 50 mg had not been administered on 9/4/2023, on 9/6/2023, on 9/9/2023 and on 9/10/2023. Hydralazine 25 mg tablet had not been administered on 9/4/2023, on 9/6/2023, and on 9/10/2023. The documentation showed N (not given) in the initial box with RN #1's initials. Continued review showed a rationale had not been documented after the medications had been omitted. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/19/2023 at 2:29 PM, RN #1 confirmed the essential medications for Residents #13 and #22 had not been administered as ordered by the physician as follows: Resident #13's Lisinopril, Clonidine, Hydralazine, Insulin Lispro, Glimepiride, and Lantus Solostar had not been administered as ordered on 9/1/2023, 9/2/2023, 9/3/2023, 9/4/2023, 9/5/2023, 9/6/2023, 9/9/2023, 9/13/2023 and 9/14/2023. Resident #22's Metoprolol and Hydralazine had not been administered as ordered on 9/4/2023, 9/6/2023, 9/9/2023 and 9/10/2023. RN #1 stated he was aware of the facility's policy to document a rationale when medications were not administered and to notify the physician if the ordered medications were withheld. RN #1 confirmed the physician was not notified of the omitted medications, and the essential medications had not been administered as ordered on the listed dates which resulted in significant medication errors. During an interview on 9/20/2023 at 4:37 PM, the Administrator and the DON stated it was their expectation that the physician was notified when a medication was not administered and that medications be administered as ordered by the physician. The DON confirmed Resident #13's 4:30 dose sliding scale Lispro insulin on 9/3/2023 and 9/6/2023, the 9:00 PM dose of sliding scale Lispro insulin had not been administered according to the physician's order on 9/5/2023 and 9/6/2023, and the 9:00 PM dose of Lantus insulin had not been administered according to the physician's order on 9/9/2023, 9/13/2023, and 9/14/2023. Resident #22's Metoprolol Tartrate had not been administered on 9/4/2023, 9/6/2023, 9/9/2023, and 9/10/2023. The Administrator confirmed the omission of certain cardiac medications and insulin would be considered a significant medication error. The DON confirmed the physician had not been notified of the significant medication errors. During a telephone interview on 9/20/23 08:51 AM, the Medical Director revealed she expected for the orders she prescribed to be followed with the parameters set for BP and pulse, and if medications were not administered, she expected a documented reason and to be notified. The Medical Director stated before 9/19/2023, she had not been made aware of the omitted medications. The Medical Director also stated Resident #13's long term glycemic control was maintained with the use of insulin and the Glimepiride medications, and no immediate harm or serious adverse outcome was done to Resident #13, but letting Blood Sugar go untreated undermined the glycemic control. The Medical Director stated she had not been made aware of any residents suffering any complications and the residents had not required any new orders or medical interventions since medications had been omitted. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/22/2023, Surveyors reviewed the education sign in sheets and new audit forms implemented which validated the corrective action plans onsite. Surveyors reviewed the Quality Assurance and Performance Improvement (QAPI) meeting sign-in sheet and interviewed QAPI members regarding the ad-hoc meeting that occurred on 9/19/2023 which discussed the implementation of the medication pass audit and the Medication Administration Record (MAR) audit. Attendees of the ad-hoc QAPI meeting included Minimum Data Set (MDS) Coordinator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Director of Operations, and the Administrator. Surveyors verified onsite the implementation of the medication pass audit and Medication Administration Record (MAR) audits. Surveyors reviewed medication pass audits, interviewed staff, and reviewed education sign in sheets for education provided that included medication error and medication hold procedure. Surveyors verified that 100% of facility nurses had received the education by reviewing education sign in sheets and interviewing staff present in the facility. Surveyors reviewed the MAR audits for all in house residents and the daily audit form of non-administered medications to be completed 5 days per week by the DON, ADON, or MDS Coordinator. Registered Nurse (RN) #1 was suspended by the facility on 9/19/2023 and terminated on 9/21/2023.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, observation, and interview the facility failed to ensure food items were properly stored in 2 of 3 freezers, failed to ensure expired food items were not available for resident use on 1 of 1 bread cart, failed to properly store food items in 1 of 2 refrigerators, and failed to ensure pots and pans were stored appropriately in 1 of 1 pot and pan storage area, which had the potential to effect 34 of 35 residents. The findings include: Review of the facility's policy titled, Food Storage, dated [DATE], showed .Food is stored and prepared in a clean safe sanitary manner .All food not in original containers will be labeled, dated, and stored .in approved containers . Review of the facility's policy titled, Pots & [and] Pans, dated [DATE], showed .Remove all food debris/grease before placing pots & pans in the sink .Wash, rinse, and sanitize pots & pans .Allow pots & pans to air dry . Review of the facility's policy titled, Cold Storage Areas, dated [DATE], showed .Cold food(s) will be stored under safe and sanitary conditions .Refrigerators and freezers are designed to keep food cold enough to prevent or slow the growth of bacteria as well as preserve the freshness and quality of foods .Date, label, and properly secure all products removed from original containers with all items labeled stating the contents inside, the date opened, and the appropriate use-by date .When labeling and dating open food items, the label should include the food item, date opened, and use-by date . Review of the facility's policy titled, Storage Periods, Use-By Guidelines, dated [DATE], showed .Food will be stored properly and used within the appropriate time period to ensure safe and high-quality food is served . Expiration date: This is the last day the product should be used for the best quality . An observation and interview on [DATE] at 10:07 AM, with the Certified Dietary Manager (CDM) in the Vegetable Freezer, showed an unsealed, unlabeled, and undated 2-gallon bag of crinkle cut French fries and an unopened, unlabeled, and undated large clear plastic bag of food item identified by the CDM as .hush puppies . The CDM stated it was her expectation that items in the freezer were sealed to maintain freshness and labeled with the contents and dated. The CDM confirmed the bag of crinkle cut French fries was not sealed, labeled, or dated, and the bag of hush puppies was not labeled or dated. The CDM confirmed the food items were not properly stored and were available for resident use. An observation and interview on [DATE] at 10:09 AM, with the CDM in the Meat and Ice Cream Freezer, showed 2 large resealable bags of frozen food identified by the CDM as chicken breasts . The 2 bags had been opened and were not labeled or dated. The CDM confirmed the 2 bags of chicken breasts were not labeled with contents or dated and were available for resident use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on [DATE] at 10:12 AM, with the CDM, the bread cart stored ,d+[DATE] loaf of white sandwich bread with an expiration date of [DATE]. The CDM stated it was her expectation that expired food items were discarded. The CDM confirmed the bread was expired and available for resident use. During an observation and interview on [DATE] at 10:19 AM, with the CDM, the drink refrigerator stored 37 plastic containers of an off-white, thick substance covered with saran wrap that were unlabeled and undated. The CDM identified the plastic containers as .pudding . and confirmed that the items were unlabeled, undated, and available for resident use. During an observation and interview on [DATE] at 10:26 AM, with the CDM, the pot and pan storage area showed 2 medium sized metal pans stacked together wet, 2 large sized metal pans stacked together wet, and 1 full size metal pan that was stored wet. The CDM confirmed the pans were stored wet and stated it was her expectation that they were air dried prior to storage.

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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** 41782 45837 Based on facility policy review, medical record review, observation and interview, the facility failed to implement appropriate infection control practices by improperly storing a Continuous Positive Air Pressure (CPAP) mask and tubing and improperly securing a catheter bag for 2 residents (Residents #15 and #33) of 35 residents reviewed for infection prevention. The findings include: Review of the facility's policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, revised on 11/2011, showed .Infection Control Considerations Related to .CPAP .Store the circuit in plastic bag, marked with date and resident's name, between uses . Review of the facility's undated policy titled, [Indwelling urinary] Catheters, Care of, Infection Control and Insertion Guidelines, showed, .Secure indwelling catheters after insertion .A sterile continuously closed drainage system should be maintained . Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Sleep Apnea, Wheezing, and Acquired Absence of Lung. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #15 was cognitively intact. The resident had shortness of breath with exertion and while lying flat and received oxygen therapy. Review of a physician's order dated 8/16/2023, showed an order for Resident #15 for CPAP (a machine to help you breathe while you are sleeping) at night. During an observation on 9/17/2023 at 11:03 AM, in Resident #15's room, the resident's CPAP mask was lying on the table next to the bed uncovered and open to air. An observation and interview on 9/17/2023 at 3:04 PM, in Resident #15's room, showed the resident's CPAP mask lying on the table next to the bed uncovered and open to air. During an interview, Resident #15 stated an unknown staff member removed it from the resident's face this morning and laid it on the table. During an observation and interview on 9/17/2023 at 3:15 PM, in the resident's room, the Director of Nursing (DON) stated Resident #15's CPAP mask was lying on the table next to the bed uncovered and open to air. The DON stated CPAP masks were to be stored in a bag when not in use to reduce the risk of infection. The DON confirmed Resident #15's CPAP mask had not been stored appropriately to prevent the risk of infection. Resident #33 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Pneumonia and Hyperkalemia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan dated 6/17/2023, showed Resident #33 preferred not to wear catheter tubing secured to the thigh to prevent pulling. Review of a quarterly MDS assessment dated [DATE] showed Resident #33 was severely cognitively impaired and required total dependence on 2 staff for bed mobility, toilet use and personal hygiene. The resident had an indwelling urinary catheter. During an observation on 9/17/2023 at 10:03 AM, Resident #33 was in bed, and an indwelling urinary catheter collection bag was attached to the tubing inside the resident and was lying on the floor on the left side of the resident's bed. During an observation and interview on 9/17/2023 at 10:11 AM, in Resident #33's room, the DON confirmed the urinary catheter collection bag was lying on the floor. The DON confirmed the collection bag was not secured off the floor to prevent the risk of infection.