STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455785	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Hills Nursing & Rehabilitation	512 Draper Dr Temple, TX 76504

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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 - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on observations, interviews, and record review, the facility failed to ensure residents had the right to self-administer medications if the IDT determined that the practice was clinically appropriate for one (Resident #10) of six residents reviewed for medication administration. The facility failed to assess, obtain physician orders, and get IDT approval for Resident #10 to self-administer her medications. This failure could place residents at risk of not receiving the proper medication, the proper dose, or the therapeutic benefits of the medications. Findings included: Review of Resident #10's face sheet printed 03/20/24, reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hypo-osmolality and hyponatremia (abnormal levels of sodium in the blood), hypertension (high blood pressure), chronic pain, migraines (severe type of headache), epilepsy (seizures), dry eye syndrome, acute bronchitis (irritation of the lungs), and seasonal allergic rhinitis (allergies). Review of Resident #10's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected resident required supervision or touching assistance for most ADLs including eating, oral hygiene, and upper body dressing. Review of Resident #10's active physician's orders reflected, Fluticasone Propionate Nasal Suspension 50 mcg/act, 1 spray in each nostril two times a day related to seasonal allergic rhinitis dated 02/25/24, Carboxymethylcellulose Sodium Ophthalmic Solution 1 % (Carboxymethylcellulose Sodium (Ophth) Instill 1 drop in both eyes three times a day for dry eyes wait at least 3-5 minutes in between administering each type of eye drop dated 1/22/23, and Ipratropium Bromide Nasal Solution 0.03 % (Ipratropium Bromide (Nasal) 2 spray in both nostrils three times a day for Allergies dated 02/25/24. There were no orders for self-administration of medications. Review of Resident #10's Medication and Treatment Administration Records for March 2024, reflected she had received the fluticasone twice a day, the carboxymethylcellulose eye drops three times a day, and the Ipratropium nasal spray three times a day. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's comprehensive care plan initiated 11/08/24 reflected, Problem - I have impaired visual function r/t cataracts, macular degeneration. Goal - The resident will have no indications of acute eye problems through the review date. Interventions - Arrange consultation with eye care practitioner as required, Identify/record factors affecting visual functioning including physiological (glaucoma, Crohn's, macular degeneration, cataracts, color discrimination, light sensitivity, dry eyes); environmental (poor lighting, monochromatic color scheme), choice (refuses to wear glasses, use mag glass, turn on lights) etc. The care plan did not address seasonal allergies or dry eye syndrome. The care plan did not address self-administration of medications. During an observation and interview on 03/20/24 at 8:12 AM, MA F prepared medications for Resident #10. MA F removed the Carboxymethylcellulose eye drops, Fluticasone nasal spray, and two tissues and walked into the resident's room. She set the medications on the residents over-the-bed table then returned to the medication cart that was in the doorway of the resident's room. She stated the resident doesn't like it when people gave her eye drops and nasal spray and she preferred to do it on her own. With her back to the resident, she pulled the oral medications for the resident. The resident was observed as she shook the bottle of Fluticasone nasal spray then administered two sprays in each nostril. The resident then administered her own eye drops and dabbed her eyes with the tissue. MA F went back into the room and checked the residents' blood pressure. She left the bottle of Ipratropium Bromide nasal spray with the resident. MA F returned to the medication cart, and with her back to the resident, she cleaned the blood pressure cuff. The resident administered two sprays in each nostril. During an interview on 03/20/24 at 3:44 PM with ADON A, she stated there were no residents in the facility at the current time that self-administered medications. She stated the resident needed a self-administration assessment completed and a physician's order to self-administer prior to the resident administering their own meds. The ADON stated handing a resident eye drops or nasal spray and watching them administer the medication is not acceptable and she added, We have to administer the medication. She stated residents could give the wrong dose if not monitored or properly trained. During an interview on 03/20/24 at 3:49 PM with MA F, she stated the dose for Resident #10's Fluticasone was one spray in each nostril. She could not remember if she had watched the resident administer the medication and she did not know how many sprays the resident administered. MA F stated a resident could have given the wrong dose or administered the medication wrong if they were not properly trained. During an interview on 03/21/24 at 1:55 PM, the ADM stated she was aware of one resident in the facility who self-administered medications. She stated residents needed an assessment and a doctor's order to self-administer and to keep medications at the bedside. She stated it did not meet her expectations that a resident administered their own medications. She stated she was not aware that the resident preferred to administer her own medication. She stated allowing a resident to self-administer without assessment and education could result in the wrong administration or possible adverse reactions. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/24 at 2:55 PM, the DON stated up until yesterday, she was not aware that Resident #10 had administered her own eye drops and nasal spray. She stated the resident may over- or underdose and may not get the benefit of the medication if they administered it wrong. She stated there was an assessment process that was completed before a resident could self-administer. She stated she expected the residents would have gone through the assessment process prior to self-administration of medication. She stated the IDT would assess the resident and the physician would write an order prior to self-administration. Review of the facility's undated Resident Rights policy reflected, 3.2. Self-Administration Residents requesting self-administration should establish the ability and knowledge to self- administer medications. Medication orders must specify those medications which the resident may self-administer. Facility nursing staff should monitor the resident and their medications for appropriate use. The resident should be periodically assessed for continued competency to self-administer. Facility staff should order new and refill medications from pharmacy for residents who self-administer medications to provide access to and adequate supplies of medications. Facility staff should monitor the remaining quantities of medications to determine if facility staff should reorder a medication before the remaining quantity is exhausted and ensure the resident is taking medications per prescribed orders. Facility should document the self-administration of medications on the resident's MAR per the medication administration schedule. Review of the facility's undated Medication and Preparation Administration policy reflected in part, 9. Medication and Preparation Administration 9.1. Prior to Medication Administration Facility staff should comply with Facility Policy, Applicable Law, and the State Operations Manual when preparing medications. Prior to preparation or administering medications, staff should follow the facility's infection control policy. 9.3. Medication Administration . To maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47795 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #55) of 8 residents reviewed for care plans. The facility failed to ensure Resident #55's comprehensive care plan has non-approved abbreviations for problems which could result in the resident's actual needs not being met. This failure could place residents at risk of receiving inadequate or unnecessary interventions not individualized to their health care needs. The findings included: Review of Resident # 55's face sheet dated 3/20/24 revealed a [AGE] year old male, admitted on [DATE] with diagnosis that include unspecified atrial fibrillation (abnormal heart rate), acute on chronic congestive heart failure(a condition in which the heart does not as well as it should), cognitive communication deficit (difficulty with thinking and how someone uses language) and dysphagia, oropharyngeal phase(swallowing problems occurring the mouth and or the throat) . Review of Resident # 55's Quarterly MDS dated [DATE] revealed a BIM's score of 13 which indicated the resident was cognitively intact. Review of Resident # 55's Care plan revised 2/28/2024 revealed a problem dated 8/4/2023 the Reads I have STM impairment. Interview with MDS Nurse on 3/21/24 at 11:45 am stated the IDT was responsible for completing the care plan and any updates as part of the team, but that she does update the care plan. When asked about Resident #55's care plan that stated STM MDS Nurse stated she was not sure what STM means but given the context she would imagine it stood for Short Term Memory loss. When asked if the facility had an approved abbreviation list for care plans, MDS Nurse state she was not sure. Interview with the DON on 3/21/24 at 1:45 PM revealed her expectations were that care plans were resident centered and that the approved abbreviations were being used so that every care giver can understand the needs of the resident. The DON stated the IDT was responsible for keeping their portion of the care plan up to date and accurate. The DON stated she was unaware of an approved abbreviation list but has found one and STM was not on it. The DON stated she guessed STM may stand for Short Term Memory, but she was not sure. The DON stated she was not aware of who used that abbreviation as so many have access to care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the ADM on 3/24/2024 at 2:00 pm revealed her expectations were that the staff used approved abbreviations when documenting in the medical record, including the care plan. The ADM stated she was not familiar with the abbreviation STM and would not have a clue what it could mean. The ADM stated that an approved abbreviation list was found and will be placed where the staff will have access to it, and they will be educated on its use. The ADM stated her expectations were that care plans reflect an up-to-date reflection of resident's medical conditions and needs. Record Review of List of Approved abbreviations revised February 2014 on 3/21/2024 at 2:30 pm revealed that STM was not on the list.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on observations, interviews, and record review the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 (Resident #57) of 16 residents reviewed for care plans. The facility failed to ensure Resident #57 comprehensive care plan had the correct medical diagnosis. This failure could place residents at risk of receiving inadequate or unnecessary interventions not individualized to their health care needs. The Findings included: Review of Resident #57's Face sheet dated 3/21/2024 revealed a [AGE] year-old female admitted on [DATE] with diagnoses that include unspecified dementia, unspecified severity with agitation (mild cognitive impairment has yet to be diagnosed as a specific type of dementia with behaviors that include agitation), insomnia (the inability to fall or stay asleep), dysarthria following cerebral infarction (a speech impairment that sometimes occurs after a stroke), Alzheimer's disease with early onset (a progressive disease that destroys memory and other important mental functions), and essential (primary) hypertension (an abnormally high blood pressure that is not the result of a medical condition) Review of Resident # 57's Quarterly MDS dated [DATE] revealed a BIM's score of 9 which indicated moderate cognitive impairment. Diagnoses listed on the MDS were Hypertension (abnormal blood pressure), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), cerebrovascular accident (when the blood flow is cut off from the brain), Non- Alzheimer's dementia (a progressive disease that destroys memory and other important mental function due to a medical condition), Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and insomnia, unspecified (trouble falling or staying asleep). Review of Resident # 57's Care plan revised on 2/2/2023 revealed a problem the resident has Diabetes Mellitus. There is no diagnosis in the medical record or the MDS. Review of Resident # 57's physician's order dated 3/21/2024 revealed resident was on a Regular Diet, Mechanical Soft (a texture modified diet that restricts foods that are difficult to chew or swallow, foods cand be finely chopped or ground to make them smaller, softer and easier to chew). No orders noted for diabetic medications or monitoring. In an interview with the DON on 3/21/24 at 1:45 PM revealed her expectations were that care plans were resident centered and were being used so that every care giver can understand the needs of the resident. The DON stated the IDT was responsible for keeping their portion of the care plan up to date and accurate. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADM on 3/24/2024 at 2:00 pm she stated her expectations were that care plans reflect an up-to-date reflection of resident's medical conditions and needs. She stated that having an incorrect diagnosis on the care plan can lead to a resident being denied quality of life. Record review of Policy Comprehensive care plans revised December 2016 on 3/21/2024 at 2:30 pm revealed that 14. The Interdisciplinary team must review and update the care plan. D. at least quarterly, in conjunction with the require quarterly MDS assessment.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47795 Based on interviews and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 9 of 30 days reviewed for RN coverage. The facility failed to ensure they had an RN on duty on 11/5/23, 11/11/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23, 12/3/23, and 12/04/23. This failure placed residents at risk of missed nursing assessments, interventions, care, and treatments. Findings include: Review of RN staffing for November 2023, revealed zero hours were worked by an RN on: 11/5/23, 11/11/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, and 11/26/23. Review of RN staffing for December 2023, revealed zero hours were worked by an RN on 12/03/23, 12/04/23, and 12/28/23. In an interview on 3/21/2024 at 11:45 am, the MDS Nurse stated that she was an RN, but because she was salary, she did not clock in. She did not remember working any of the missing days (11/5/23, 11/11/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23, 12/3/23, and 12/04/23.) In an interview on 3/21/2024 at 1: 45 PM with the DON, she stated she was not aware of the lack of 8-hour RN coverage for the dates of 11/5/23, 11/11/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23, 12/3/23, and 12/04/23. The DON stated she thought the staffing coordinator would make sure the requirement was met. The DON did state that she was unable to remember if she was in the building for the dates that were missing 8-hour RN coverage. The DON stated that she was available by phone and lived 10-minutes away, so she did not see any potential for harm as she was available if needed. In an interview on 3/21/2024 at 2:00 pm with the ADM, she stated that she was not aware of the holes in RN coverage for the dates of 11/5/23, 11/11/23, 11/12/23, 11/18/23, 11/19/23, 11/25/23, 11/26/23, 12/3/23, and 12/04/23. The ADM stated she was aware of the regulation that required 8 hours of RN coverage each day, 7 days a week. The ADM stated her expectations were that the facility met the requirement of RN coverage. The ADM stated that she could not confirm there was an RN in the building because both the DON and the MDS Nurse were salary employees and did not punch in. She stated that the DON was available by phone, and she felt that while there was always potential for harm to the residents because of the lack of coverage in the building, she felt there was no actual harm because the DON was always available by phone. Record Review on 3/21/2024 at 1:30pm of Policy titled Department Supervision, Nursing undated revealed 2. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47795 Based on observations, interviews, and record review, the facility failed to ensure the nurse staffing data was posted as required for 1 of 3 days (03/19/2024) reviewed for nursing services and postings. The facility failed to post the required staffing information for 03/19/2024. This failure could place residents, their families, and facility visitors at risk of not having access to information regarding staffing data and facility census. Findings include: Observation of posted staffing sheet on 3/19/2024 at 9:24 AM revealed the sheet did not have the total hours each discipline (CNA, LVN, and RN) worked posted. In an interview on 3/19/2024 at 1:30 pm with the DON, she stated she was not aware that the staffing sheet had to have each discipline's total hours worked posted. The DON stated that the staffing coordinator was responsible for the positing of the form, but the DON and the Adm are responsible for completing the form. The DON stated she felt that most people would be able to find that the information on the form would meet their information needs. In an interview on 3/19/2024 at 2:45 pm with the ADM, she stated she was not aware of the requirement for hours being included in the staffing posted. The ADM stated the facility did not have a policy for staffing posting, they follow regulations. She stated being out of compliance did not meet her expectations. She stated not having the total hours posted for each discipline could result in the facility being short staffed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observations, interviews, and record review the facility failed to ensure that residents were free of a medication error rate of 5% or greater (9.68%) for 3 (Resident #10, Resident #37, and Resident #56) of 6 residents reviewed for medication administration. 1) The facility failed to ensure LVN E primed the insulin pen prior to administering insulin to Resident #37. 2) The facility failed to ensure RN B primed the insulin pen prior to administering insulin to Resident #56. 3) The facility failed to ensure MA F administered the proper dose of Fluticasone Propionate to Resident #10. These failures placed residents at risk of incorrect doses and not receiving the intended therapeutic benefit of the medications prescribed by the physician. Findings included: 1) Review of Resident 37's face sheet printed 03/20/24 reflected a [AGE] year-old female originally admitted to the facility 05/26/22 and readmitted [DATE]. Her diagnoses included type 2 diabetes mellitus without complications (a condition that affects the way the body processes blood sugar) and type 2 diabetes mellitus with diabetic neuropathy - unspecified (nerve damage often affects hands and feet). Review of Resident #37's annual MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Review of Resident #37's comprehensive care plan updated 02/27/24 reflected she had type 2 diabetes with diabetic neuropathy. The goals were to be free from hyper- or hypoglycemia and have no complications related to the diabetes. Review of Resident #37's physician order dated 12/08/23 reflected, Humalog injection solution (Insulin Lispro) Inject as per sliding scale if 150 - 200 = 2, 201 - 250 = 4, 251 - 300 = 6, 301 - 350 = 8, 351 - 400 = 10, > 400 give 10 and call MD, subcutaneously before meals for diabetes. During an observation and interview on 03/19/24 at 6:36 AM LVN E checked Resident #37's blood sugar and obtained a result of 159. After reviewing the sliding scale, she stated the resident would receive 2 units of Humalog insulin. LVN E removed the insulin pen from the medication cart, removed the cap then cleaned the end of the pen, dialed the knob to 2 units, then attached the needle. She entered the room, cleaned the resident's skin, and pushed the knob to administer the medication. She did not prime the needle. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Review of Resident #56's face sheet printed 03/21/24 reflected an [AGE] year-old female admitted to the facility 01/12/23. Her diagnoses included Alzheimer's disease and type 2 diabetes mellitus without complications (a condition that affects the way the body processes blood sugar). Review of Resident #56's annual MDS assessment dated [DATE] Section C (Cognitive Patterns), reflected a BIMS score of 8 indicating moderately impaired cognition. Review of Resident #56's comprehensive care plan revised 02/02/23 reflected the resident had diabetes mellitus. The goals were to be free from hyper- or hypoglycemia and have no complications related to the diabetes. Review of Resident #56's physician order dated 01/03/24 reflected, Insulin Glargine solution 100 unit/ml inject 10 unit subcutaneously one time a day for diabetes POC glucose q am and notify provider for glucose < 70 or > 225. During an observation and interview on 03/19/24 at 7:18 AM, RN B checked Resident #56's blood sugar and obtained a result of 141. She stated the resident was getting a long-acting insulin not sliding scale so she would administer the 10 units as ordered. RN B removed the insulin pen from the medication cart, removed the cap then cleaned the end of the pen, dialed the knob to 10 units, then attached the needle. She entered the room, cleaned the resident's skin, and pushed the knob to administer the medication. She did not prime the needle. 3) Review of Resident #10's face sheet printed 03/20/24, reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Hypo-osmolality and hyponatremia (abnormal levels of sodium in the blood), hypertension (high blood pressure), chronic pain, migraines (severe type of headache), epilepsy (seizures), dry eye syndrome, acute bronchitis (irritation of the lungs), and seasonal allergic rhinitis (allergies). Review of Resident #10's admission MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. Section GG (Functional Abilities) reflected resident required supervision or touching assistance for most ADLs including eating, oral hygiene, and upper body dressing. Review of Resident #10's comprehensive care plan initiated 11/04/24 did not address seasonal allergies. The care plan did not address self-administration of medications. Review of Resident #10's physician order dated 02/25/24 reflected, Fluticasone Propionate Nasal Suspension 50mcg/act, 1 spray in each nostril two times a day related to seasonal allergic rhinitis. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 03/20/24 at 8:12 AM, MA F prepared medications for Resident #10. MA F Fluticasone nasal spray from the medication cart and walked into the resident's room. She set the medication on the residents over-the-bed table then returned to the med cart that was in the doorway of the resident's room. She stated the resident doesn't like it when people gave her nasal spray and she preferred to do it on her own. With her back to the resident, she pulled the oral medications for the resident. The resident shook the bottle of Fluticasone nasal spray then administered two sprays in each nostril. MA F went back into the room and administered the oral medications. During an interview on 03/20/24 at 03:27 PM, LVN C described the process of administering insulin with an insulin pen. She stated she removed the cap from the pen, cleansed the rubber seal at the end with alcohol, let it dry, opened the needle then attached it to the pen. She stated she then twisted the knob to the desired dose. She cleansed the resident's skin, pressed the needle to the skin, then pressed the knob until it clicked and held it there for several seconds. She stated she had never had formal training on using insulin pens. She stated the insulin pen was only primed the first time it was used. She stated she was not aware that the manufacturer instructions include a test dose of 2 units each time the pen is used. She stated not priming the needle could result in an inaccurate dose of insulin being administered. During an interview on 03/20/24 at 03:27 PM, LVN D described the process of administering insulin with an insulin pen. She stated, First clean the glucometer and check the resident's blood sugar. If the resident gets sliding scale, determine the dose, long-acting insulin will have the dose in the order. Get the pen from the cart, put the need on, turn the knob to the right dose then administer. She stated she did have training about a month ago on insulin. She stated insulin pens were primed with one unit of insulin the first time the pen was used. During an interview on 03/20/24 at 3:44 PM with ADON A, she stated insulin pens were supposed to be primed with 2 units every time the pen was used. She described the process of insulin administration with an insulin pen ad stressed priming the needle every time a dose was given. She stated she had recent training on insulin. She stated the training was not online, they sat at the nurses' station and talked about it. During an interview on 03/20/24 at 3:49 PM with MA F, she stated the dose for Resident #10's Fluticasone was one spray in each nostril. She could not remember if she had watched the resident administer the medication and she did not know how many sprays the resident administered. MA F stated a resident could have given the wrong dose or administer the medication wrong if they were not properly trained. During an interview on 03/21/24 at 1:55 PM, the ADM stated she was not familiar with insulin pens. She stated it was her expectation that the nurses followed the physician orders and the manufacturers guidelines. During an interview on 03/21/24 at 2:55 PM, the DON stated she was aware that the insulin pens needed to be primed every time the pen was used. She stated, It never crossed my mind that the nurses did not know that the pens needed to be primed. She stated by not priming the pen and needle, the resident would not receive the correct dose of insulin. Review of the facility Insulin Administration policy, revised 09/14, reflected in part, (continued on next page)

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	455785	A. Building B. Wing	03/21/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose To provide guidelines for the safe administration of insulin to residents with diabetes. Preparation 1. Only appropriately licensed or certified personnel shall draw and administer insulin. 2. Only the person who draws up the insulin for injection can inject it. 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. 4. The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin. 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use . Insulin Delivery The forms of insulin delivery include: 1. Syringes - insulin syringes must match the unit dose (e.g., 100 unit/mL insulin must be administered in a 100 unit/mL insulin syringe). 2. Pumps - provide continuous insulin delivery (basal insulin) and manual or programmed surges (bolus insulin) at mealtime or other times via a catheter. 3. Pens - containing insulin cartridges deliver insulin subcutaneously through a needle. 4. Jet Injectors - inject insulin as a fine stream into the skin. (These may be advantageous for residents who fear needles, but long-term use is not recommended.) 5. Inhaled - powdered inhalable insulin (Exubera(R)) is rapid-acting insulin that may be prescribed to replace injectable rapid-acting insulin for some residents . The policy described the procedure for insulin injections via syringe. The policy did describe the use of insulin pens. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the website https://uspl.lilly.com/humalog/humalog.html#ug1, accessed 03/20/24, reflected the manufacturer's instructions for using the Humalog Kwik Pen. The site reflected, Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime you Pen, turn the dose knob to select 2 units. Step 7: Hold you Pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the needle, and repeat priming steps 6 to 8 . Review of the Lantus Solostar Injection Guide retrieved from https://www.lantus.com/how-to-use/how-to-inject/?utm_source=bing&utm_medium=cpc&utm_campaign=Lantus+-+DTC_MSFT_BRND_Pen_AWA_SEA_ALL M_US_EN+KW+-+EN+BR_ALL&utm_term=lantus+solostar+pen+instructions&gclid=a255634bdad41540282 2054fb65c712b&gclsrc=3p.ds#solostar-pen on 03/20/24, reflected in part, Step 3. Perform a safety test. Dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Always perform the safety test before each injection.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44317 Based on observations, interviews, and record review the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions, and the expiration date for 1 (200 hall nurse cart) of 4 medication carts and 1 (100/200 hall) of 2 med rooms reviewed for med storage. The facility failed to ensure the 200-hall nurse medication cart was locked when unattended. The facility failed to monitor the temperature of the refrigerator in the medication room where temperature-sensitive medications were stored. The facility failed to ensure insulin pens were dated when opened. The facility failed to remove expired insulin from the med cart. These failures place residents at risk for receiving medications which were ineffective and/or not safe. Finding included: An observation on 03/19/24 at 6:29 AM revealed LVN C walked away from the 200-hall nurse medication cart without locking the cart. During an observation and interview on 03/19/24 at 7:34 AM in the 100/200 hall medication room, revealed the medication refrigerator Daily Temperature Log in a clear plastic sleeve attached to the front of the refrigerator. Temperatures were recorded on 10 of 19 days for March and 17 of 19 days for February. Five of the recorded temperatures recorded were below the acceptable range of 36 - 46 degrees. The DON stated nursing was responsible for monitoring the refrigerator temperatures in the medication room. She stated it was her expectation that the temperatures were monitored daily, and action taken for out-of-range temperatures. She stated medications not stored at the correct temperature may have been ineffective. An observation on 03/19/24 at 7:39 AM of the 200-hall nurse cart revealed three insulin pens opened and partially used, and without an opening date. An observation and interview on 03/19/24 at 7:40 AM of the 200-hall nurse cart revealed an insulin pen with an open date of 01/21/24. LVN C stated insulin was good for 28 days after the pen was opened. She stated if the pen was not dated, the insulin should not be given as it may have expired. She stated expired medications may not be effective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/20/24 at 3:27 PM, LVN C stated the night shift nurses monitor the med room refrigerator temperatures per policy. She stated anything in the refrigerator such as eye drops, insulin, or IV antibiotics may not be good if kept at the wrong temperature. She stated the medication carts were supposed to be locked at all times except when being used by authorized staff. She stated anyone could have gotten into an unlocked med cart and taken anything. During an interview on 03/20/24 at 3:27 PM, LVN D stated certain medications needed to be refrigerated to ensure they were effective. She stated the night shift nurse was responsible for checking the temperature of the refrigerator in the medication rooms. She stated never leave a medication cart unlocked because, anybody can get in there. She stated insulin was supposed to be dated by the nurse when it was opened, and it was good for 28 days after. She stated outdated or expired meds may not be the right strength or may not work properly. During an interview on 03/20/24 at 3:44 PM, ADON A stated the night shift nurses monitored refrigerator temperatures. She stated some medications need to be stored at a specific temperature and not being at that temp could ruin the medication. She stated if she found an opened and undated insulin pen, she would toss it. She stated the nurses or medication aides were responsible for removing expired medications from the medication carts. She stated expired medications could cause adverse reactions or not give the intended dose. During an interview on 03/21/24 at 1:55 PM, the ADM stated the night shift nurses were responsible for checking the medication room refrigerator temperatures. She stated the ADONs oversee the process. She stated it did not meet her expectations that the refrigerator in the 100/200-hall medication room was not monitored routinely. She stated if not stored at the proper temperature, the medications could go bad which could cause adverse effects for the resident. She stated she expected the medication carts to be locked when not in use. She stated she was not familiar with insulin pens. She stated it was her expectation that the nurses followed the physician orders and the manufacturers guidelines. During an interview on 03/21/24 at 2:55 PM, the DON stated insulin pens were good for 28 days after they had been opened. She stated expired medications could be ineffective and some could make you sick. She stated insulin pens, and everything else, should be dated when opened. The person who opened the pen, bottle or vial was responsible for dating it. She stated she expected medication carts to be locked when not in use. Unlocked carts could be accessed by anyone. Review of the medication refrigerator Daily Temperature Log reflected, Please use this form to record AM and PM temperature readings for medication refrigerators. Acceptable range is 36-46 degrees. Notify management for temps out of range. Review of the undated Medication and Preparation Administration policy reflected in part, 9.1. Prior to Medication Administration Facility staff should comply with Facility Policy, Applicable Law, and the State Operations Manual when preparing medications. Prior to preparation or administering medications, staff should follow the facility's infection control policy. The following general recommendations should be utilized during preparation of medication: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-medication should not be administered if not appropriately labeled. -facility staff should place an opened-on date on the medication label for medications with limited expiration date upon opening. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained always for all resident information when not in use. Review of the undated Delivery, Receipt and Storage of Medications policy reflected in part, 6 .3. Storage of Medication The facility should ensure that only authorized facility staff should have access to the medication storage areas. Authorized facility staff should include nursing staff and those authorized to administer medications. Scheduled medications should be stored in a separate locked area within the medication carts or medication room. The facility should ensure the medications requiring refrigeration are stored appropriately, and the food is not stored with refrigerated medications. A policy and procedure regarding medication room refrigerator temperatures was requested. The policy was not provided prior to exit from the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49048 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safely for one of one kitchen reviewed for food labeling and storage. 1. The facility failed to ensure the food was properly stored in the panty, refrigerator, and freezer. This deficient practice could place residents at risk of foodborne illness. Findings included: An observation on 03/19/24 at 6:30 AM of the facilities only refrigerator revealed the following: - On the second shelf revealed a small size plastic container with a lid containing a brown liquid. The small plastic container was not labeled with the contents or a use by date. - An opened white box, labeled garlic. Observed inside the open box was an opened bag of garlic on the inside of the box. Neither the box nor bag was labeled with an opened on and use by date. - A white jug labeled whole milk was observed, it was not labeled with an opened date. - A white jug labeled chocolate milk did not contain an opened date. An observation on 03/19/24 at 6:35 AM of the facilities only refrigerator revealed the following: - An opened brown box labeled Eggo waffles was not labeled with an opened on and use by date. An observation on 03/19/24 at 6:36am, on the bottom shelf of a stainless-steel table in the kitchen prep area, was a bright green plastic storage container. Inside the storage container was an opened sleeve of what appeared to be plastic container lids and other unidentifiable items. On top of those items were four individual plastic bags containing one slice of white bread. These were not labeled and dated. In an interview on 03/19/24 with Dietary Staff stated the bread was from last night's dinner and that's not where they belong. They should not be there. An observation on 03/19/24 at 6:36am, of the facilities only pantry revealed the following: - A plastic container with a black lid, a label identified the contents as Corn Flakes, the label did not contain an opened on and use by date. - An opened white box contained smaller cartons of liquid, with blue and pink markings. The container was not labeled with an opened on and use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An opened white plastic container labeled Peanut Butter. The box did not contain an opened on and use by date. - An opened white box labeled Long Grain Rice. The box did not contain an opened on and use by date. - An opened plastic bag: contents appeared to be a bright multicolored cereal. The bag was loosely twisted at the top and was not labeled with an opened on and use by date. Interview with the DA at 1:30pm on 3/21/2024 revealed, staff have to put a label on it with the date it was opened and store it in the proper place. It's the entire staff's responsibility to ensure everything is labeled properly. She identified potential harm as residents eating spoiled or contaminated food. Interview with the DM at 1:40pm on 3/21/2024, revealed Everything should be closed securely, have an open and use by date. Everyone is responsible for labeling and storage. She identified potential harm as, foodborne illness and contamination. She stated, My expectation is that foods are labeled consistently. She identified herself as responsible for training kitchen aids on the process for labeling and storage. Record Review at 10:15am on 3/20/2024 Policy entitled Food Storage 03.003 revealed the following. Procedure: Section 1. Dry Storage Rooms, subsection d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. Section 2. Refrigerators, subsection d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Section 3 Freezers, subsection e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.