STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495112	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guggenheimer Health and Rehab Center	1902 Grace Street Lynchburg, VA 24504

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49456 Based on observation and staff interview, the facility staff failed to knock on the door of resident rooms prior to entering on one unit of three units. The findings included: The facility staff failed to knock on approximately six room doors prior to entering the room on unit one. On 12/9/24 at 12:15 p.m. an observation was conducted on unit one. During the observation CNA#3 (CNA3) (certified nursing assistant) was observed serving lunch trays to the residents and did not knock on the doors prior to entering the residents' rooms. On 12/9/24 at 12:25 p.m. an interview was conducted with CNA3. CNA3 said, I knock on all the doors that are closed only. CNA3 stated she knew she was supposed to knock prior to entering and that the director of nursing had reeducated her on this. On 12/9/24 at 12:35 p.m., continued observations were made on unit one and CNA3 continued to enter multiple resident's rooms without knocking on the door prior to entering the rooms. On 12/10/24 a review of facility documentation was conducted. The facility document titled, Resident Rights, read in part, .the resident has the right to be treated with respect and dignity. On 12/10/24 at approximately 11:30 a.m., an end of day meeting was conducted with the administrator and corporate staff, and they were made aware of the above concerns. No new information was provided prior to exit.

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

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

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F 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. 41449 2. For resident #107 (R107), the facility staff failed to review and revise the care plan when the air mattress and enhanced barrier precautions were discontinued. On 12/9/24 at approximately 11 a.m., R107 was visited in his room. It was noted that R107 was not on an air mattress and there was no signage to indicate the resident was on enhanced barrier precautions. R107 was noted to be confused, and responses were nonsensical, therefore the resident was not interviewed about when these items were discontinued. On 12/9/24 a clinical record review was conducted. This review revealed within R107's care plan, interventions that read, Enhanced barrier precautions to be maintained for the duration of the resident's stay due to active wounds. Staff to wear a gown and gloves while engaging in high contact patient care activities and 9/23/24 check air mattress. On 12/9/24 at approximately 4 p.m., an interview was conducted with a registered nurse (RN #2), who was the unit manager. When asked about care plans being reviewed and revised, the unit manager said, I have the ability. When notified that R107's care plan indicated he was on an air mattress and enhanced barrier precautions, but neither was noted at the time of survey, the unit manager said, That should have happened when he was downstairs, the manager downstairs should have updated. The unit manager confirmed she was not aware when R107 was taken off an air mattress. On 12/9/24 at approximately 4:20 p.m., an interview was conducted with Licensed practical nurse (LPN #4) who had previously been the unit manager for unit 1. When asked about R107 being taken off enhanced barrier precautions and the air mattress, LPN #4 said, I'm not sure when EBP ended. LPN #4 looked at R107's chart and said when he had surgery, [the amputation] all his wound were healed so the air mattress probably ended them. When notified that both items were still on R107's care plan, LPN #4 stated she though infection control would have updated the care plan when EBP ended. According to R107's physician orders the enhanced barrier precautions order was discontinued on 11/14/24. The order for an air mattress was discontinued on 11/7/24. The facility policy titled, Care Planning- Comprehensive Person-Centered was reviewed. The policy read in part, . 16. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans . On 12/10/24 at 11:30 a.m., during an end of day meeting, the facility administrator and corporate staff were made aware of the above findings. No additional information was provided. 49456 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to review and revise the care plan for two resident's, Resident #103 (R103) and Resident #107 (R107), in a survey sample of 21 residents. The findings included: 1. The facility staff failed to review and revise R103's care plan when orders were discontinued. On 12/10/24, observations of R103 revealed no oxygen was in use. On 12/10/24 a review of the clinical record was conducted. The care plan was reviewed for R103. The most recent care plan read in part, .altered respiratory status - oxygen settings O2 via by nasal cannula per order. R103 had no active order for oxygen in his clinical record. R103 had a discontinued order for oxygen on November 13, 2024. On 12/10/24 at 9:20 a.m. an interview was conducted with the director of nursing (DON). The DON said that clinical meetings were held daily, that she runs an order summary report, and the clinical staff reviews the report, and updates are made to the care plans in the clinical meeting daily. The DON stated, an order that was discontinued in November should not still be on the care plan. On 12/10/24 at approximately 11:30 a.m., an end of day meeting was conducted, and the above concerns were discussed with the administrator and corporate staff. No additional information was provided prior to exit conference

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49456 Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of care regarding medication administration for one resident, Resident #115 (R115) out of a survey of 21 residents. The findings included: The facility staff failed to ensure that medication was not left at bedside, in the resident's room after medication administration. On 12/9/24 at 12:00 p.m., a tour of the nursing facility's unit one was conducted. During the tour of the unit, the surveyor observed a medication cup sitting on the bedside table with the resident's name and room number written on the cup with a black marker. On 12/9/24 at 12:15 p.m., an interview was conducted with the charge nurse on unit one, licensed practical nurse, LPN#5. LPN#5 stated, it is medication in the cup. I am not sure what kind of cream it is. LPN#5 removed the medication cup filled with cream from the bedside and apologized to R115 for it being left in his room at bedside. On 12/9/24 at 12:20 p.m., an interview was conducted with R115 about the medication at bedside. R115 stated, I don't know the name of the cream, but they used it on my skin on my buttocks and it healed it right up after about a week or so. The aide would get it from the nurse to put on my butt in the mornings. On 12/10/24 a review of a facility document was conducted. The facility documentation titled, Administration Procedures for All Medications, read in part, .medications will be administered in a safe and effective manner. On 12/10/24 at approximately 11:30 a.m., an end of the day meeting was conducted with the administrator and corporate staff to discuss the above concerns. No additional information was provided prior to exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41449 Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to provide ADL (activities of daily living) care to one resident (Resident #102- R102) in a survey sample of 21 residents. The findings included: For R102, the facility staff failed to provide routine showers. On 12/9/24, a clinical record review was conducted of R102's chart. This review revealed that from 11/20/24-12/9/24, R102 had only received one shower. According to R102's most recent minimum data set (an assessment) with an assessment reference date of 11/13/24, R102 was dependent on facility staff for bathing and showering. On 12/10/24 at 9:19 a.m., an interview was conducted with R102. The resident was asked about showers and said, I get them once a month, they act like they don't know what day I'm to get them. When asked if she wants them more often, R102 said, Yes, my head itches and it drives me crazy. On 12/10/24 at 9:23 a.m., an interview was conducted with a certified nursing assistant (CNA #2). CNA #2 reported that showers are given twice a week, and they have a schedule at the nurse's station. CNA #2 also reported that showers are documented in the computer/electronic health record of the resident. On 12/10/24 at 9:25 a.m., the surveyor reviewed the shower schedule at the nursing station which indicated R102 was to receive showers on Wednesday and Saturdays. On 12/10/24 at approximately 9:45 a.m., an interview was conducted with the director of nursing (DON). The DON confirmed that showers are given, twice weekly and then as needed. The DON accessed R102's clinical record and confirmed that the only shower documented was on 12/8/24. The DON did state that R102 received a bed bath on 11/27, 11/29, 12/1, 12/3, 12/4, 12/8. When asked if a bed bath was an acceptable alternative to a shower, the DON said, It depends on their preference and how they are feeling, if they refuse a shower, I encourage a bed bath, but a shower is always better. On 12/10/24 at approximately 11:30 a.m., during an end of day meeting, the facility administrator and corporate staff were made aware of the above findings. No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 21875 Based on staff interview and clinical record review, the facility staff failed to follow physician orders for two of twenty-one residents in the survey sample (Residents #105 and #111). The findings include: 1. Resident #105 was not administered the medications gabapentin, Wellbutrin and midodrine as ordered by the physician. Resident #105 (R105) was admitted to the facility with diagnoses that included heart failure, stroke, coronary artery disease, COPD (chronic obstructive pulmonary disease), hypotension, neuropathy and depression. The minimum data set (MDS) dated [DATE] assessed R105 with moderately impaired cognitive skills. R105's clinical record documented the following physician orders listed with the date ordered. 12/20/21 - Gabapentin 200 mg (milligrams) twice per day for treatment of neuropathy. 3/22/24 - Wellbutrin extended release 150 mg two times per day for treatment of depression. 6/12/24 - Midodrine 10 mg three times per day for treatment of hypotension. R105's medication administration record documented the 8:00 p.m. dose of Wellbutrin extended release 150 mg was not administered on 11/28/24. R105's evening dose of gabapentin 200 mg was not administered on 11/30/24 and the morning and evening doses were not administered on 12/2/24. R105's 8:00 a.m., 2:00 p.m. and 8:00 p.m. doses of midodrine 10 mg were not administered on 12/3/24. A nursing note documented on 11/28/24 that R105's Wellbutrin was on order from the pharmacy and not available for administration. Nursing notes on 11/30/24 and 12/2/4 documented R105's gabapentin was on order from the pharmacy and not available for administration. A nursing note dated 12/3/24 documented concerning R105's midodrine, Medication unavailable. Medication reordered. Omnicell [backup supply] checked; not in stock in omnicell. On 12/9/24 at 4:10 p.m., the registered nurse unit manager (RN #2) caring for R105 was interviewed about the gabapentin, Wellbutrin and midodrine not administered as ordered. RN #2 stated she was not sure why the medications were not available/administered. On 12/10/24 at 10:00 a.m., the director of nursing (DON) was interviewed about R105's missed doses of gabapentin, Wellbutrin and midodrine. The DON stated the gabapentin was stocked in the Omnicell and should have been accessed by the nurse. The DON stated she was not sure if the unavailability of the Wellbutrin and midodrine was caused by an ordering discrepancy or poor pharmacy delivery times. This finding was reviewed with the administrator and regional consultants during a meeting on 12/10/24 at 11:05 a.m. with no further information presented prior to the end of the survey. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41449 2a. For Resident #111 (R111), the facility staff failed to follow a physician's order regarding notification of the medical provider when the resident's blood sugar was below 70 and above 400. On 12/9/24, in the afternoon, a clinical record review was conducted of R111's chart. This review revealed that R111 had a physician order with the Humalog sliding scale insulin order that indicated to notify the MD [medical doctor] if the blood sugar was 70 or below, or greater than 400. According to the medication administration record, R111 had multiple instances of her blood sugar exceeding 400 and there was no indication that the doctor was made aware. On 12/1/24, at 4:30 p.m., the blood glucose level was 445. On 12/3/24, the resident's blood sugar readings were 459, 525, 408. On 12/6/24, the blood sugar was recorded as having been 500 and 435. On 12/7/24, the resident's blood sugar at 7:30 a.m., was 409, and on 12/9/24 the blood glucose was 410 and 428. Within the clinical record was no evidence of the doctor being made aware. According to the nursing notes, an entry dated 11/23/24, read, Pt observed clammy and diaphoretic, unable to arouse. Blood sugar check 24 via fingerstick. Emergency dose of Glucagon given from Emergency stock box. Second dose of glucagon given 15 after first, with blood sugar recheck at 37. Pt able to open eyes but remains lethargic and clammy. Again, there was no evidence that doctor was made aware. On 12/9/24 at approximately 3:45 p.m., an interview was conducted with registered nurse #2 (RN #2), who was the unit manager. When asked where staff would document that the doctor was notified when R111's blood sugar was outside of the parameters set, RN #2 said, a lot of times they will just call. They should always notify the provider, and it should be documented in the progress notes. On 12/9/24 at approximately 4:10 p.m., the surveyor was at the nursing station reviewing the provider communication book, where nursing writes notifications to the medical providers. The director of nursing (DON) approached the surveyor and asked if she needed assistance. The surveyor explained that she was looking to see if there was evidence of the facility staff notifying the doctor of blood sugars being outside of the range. The DON said, It should be documented in the progress notes. The MD book at the station is not a formal document. There was no indication within the provider communication book that they were made aware of R111's instances of the blood glucose being greater than 400 or the incident where the blood sugar was 24, as noted above. On 12/10/24 at 9:30 a.m., during a follow-up interview with the DON, she was made aware of the above findings. She stated that, I can't give orders and if their blood sugar is outside of parameters, it should give an indication of the need for additional orders by calling the doctor. On 12/10/24 approximately 10:30 a.m., an interview was conducted with the facility's nurse practitioner (NP). The NP was asked about R111 and reported that R111 is a type 1 diabetic and very brittle. The NP stated she was not aware of the incident where R111's blood sugar was 24 and 2 doses of glucagon had to be administered. The NP asked the surveyor if the resident was sent to the hospital, the surveyor explained that according to the clinical record the resident was not. On 12/10/24 at 11:10 a.m., during a meeting with the facility administrator and corporate staff, they were made aware of the above findings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided. 2b. For R111, the facility staff failed to follow physician orders by obtaining labs as ordered. On 12/9/24, a clinical record review was conducted of R111's chart. This review revealed a physician order that read, renal panel, every day-shift, every 2 weeks on Wednesday. According to the results tab of the chart, the renal panel was obtained on 10/30/24 and 11/13/24. There was no evidence that the renal panel was obtained on 11/27/24. The facility policy regarding physician orders was requested. The facility provided the survey team with a policy titled, Medication and Treatment Orders which was reviewed. The policy did not address that physician orders for labs or notifications. On 12/10/24 at 9:30 a.m., an interview was conducted with the director of nursing. She was made aware of the physician ordered lab that was not obtained on 11/27 as ordered for R111. On 12/10/24 at 11:10 a.m., during a meeting with the facility administrator and corporate staff, they were made aware of the above findings. No additional information was provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41449 Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide a physician ordered therapeutic diet for one resident (Resident #108-R108) in a survey sample of 21 residents. The findings included: For R108, who was on a pureed diet, the facility staff failed to provide a diet with a pureed texture. On 12/9/24 at approximately 11 a.m., R108 was visited in her room. R108 was asleep. In R108's room was a sign that read, Level 1 puree with NECTAR thick liquids. Compensatory Swallow Strategies: . Ensure the puree item is smooth & no pieces. On 12/9/24 at approximately 1 p.m., R108's lunch tray was observed, the food was noted to have what appeared to be ground chunks. The two CNA's passing the meal trays on the second floor were asked about the consistency of the food and reported that this was what the pureed foods usually look like. On 12/9/24 at approximately 1:10 p.m., the director of nursing (DON) was asked to view the document/sign posted in R108's room and then observe the meal tray. The DON confirmed that the food was what she considered a ground texture versus pureed. The DON then started educating the CNA's that pureed is supposed to be smooth and creamy texture. According to R108's diagnosis, it included but was not limited to: Dysphagia unspecified and dysphagia, pharyngeal phase. According to R108's physician orders, the diet order read, Regular diet, Puree texture, Nectar liquids consistency. According to R108's care plan, a focus area read, Mechanically altered diet 2* Decreased chewing, tolerating current diet. BMI > 24. Fed at meals. Dx [diagnosis]. of Failure to thrive. The interventions included, diet as ordered. The facility administration was asked to provide the speech therapy documentation for R108. The facility provided a progress note from the speech therapist that was dated 12/5/24. The note read in part, Patient screened by ST [speech therapy] due to CNA report of pt [patient] pocketing of food. Patient currently on a pureed diet with nectar thick liquids and is MAX assist for feeding The facility policy titled; Specialized Diets was reviewed. The policy read in part, . 2. A mechanically altered and/or therapeutic diet must be prescribed by the resident's attending physician . 7. Meals will be prepared and served according to the prescribed diet . On 12/10/24, during an end of day meeting the facility administrator and corporate staff were made aware of the above findings. No additional information was provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49456

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 41449 2. For R117, the facility staff failed to administer oxygen at the rate ordered by the physician. On 12/9/24 at approximately 11 a.m., an observation was conducted of R117. R117 was lying in bed, oxygen was infusing via a nasal cannula. The oxygen concentrator was observed to be set between 2 1/2-3 liters per minute. On 12/9/24, a clinical record review was conducted of R117's chart. According to a physician order, which read, o2 2 liters continuous via nasal cannula . According to R117' care plan, an intervention read as, 02 as ordered as resident will allow. Resident often refuses. 02 during the day as needed as resident desires. On 12/9/24 at 3:54 p.m., another observation was made of R117, who was again in bed with oxygen being administered by nasal cannula. R117 stated she didn't know what rate her oxygen was supposed to be at when asked. The concentrator was observed again and was noted to be on 2 1/2 liters. On 12/9/24 at 3:56 p.m., the surveyor had licensed practical nurse (LPN #3) accompany her to R117's room. LPN #3 confirmed the oxygen was set at 2 1/2 liters and should have been 2 liters. The nurse was asked about oxygen being administered at a different rate than ordered and LPN #3 said, For 1 it's doctor's order. According to the facility policy titled, Oxygen Administration, which read in part, Preparation- 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . On 12/10/24 at approximately 11:30 a.m., during an end of day meeting, the facility administrator and corporate staff were made aware of the above findings. No additional information was provided. 49456 Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to provide oxygen at the physician ordered rate for two residents, Resident #115 (R115) and Resident #117 (R117) out of a survey of 21 residents and failed to store the respiratory equipment to prevent contamination for one resident, R115 out of a survey of 21 residents. The findings included: 1. For R115, the facility staff failed to ensure that the oxygen orders by the physician were being followed and failed to store respiratory equipment in a bag when not in use to prevent contamination. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 12:00 p.m., a tour of the nursing facility's unit one was conducted. During the tour of the unit, the surveyor observed a CPAP (continue positive airway pressure) mask laying in a bed bath basin on the bedside table. R115 oxygen concentrator setting was set on 1.5 liters per minute via nasal cannula. On 12/9/24 at 12:15 p.m., an interview was conducted with the charge nurse on unit one, licensed practical nurse, LPN#5. LPN#5 stated, the CPAP mask should be in a bag and not sure why it is not. LPN#5 left the room and did not place the mask in the bag to prevent contamination. Three other employees entered the room and did not correct the issue with the CPAP mask, so R115 placed the CPAP mask in the bag at bedside. LPN#5 checked the oxygen concentrator and said, the setting is at 1.5 liters but should be on 2 liters when he is using the oxygen. On 12/9/24 at 12:20 p.m., an interview was conducted with R115. R115 said, I remove the mask in the morning and place it in the bed bath basin because it is by the bedside, and I can reach it, but the bag is over here. R115 stated that he only used oxygen at bedtime and that it is 1.5 liters per minute, not 2 liters per minute, by nasal cannula. On 12/9/24 at 2:30 p.m., a review of the clinical record was conducted. There was an order in R115's clinical record that read, 11/15/24 at 16:29 Oxygen at 2 liters by nasal cannula due to hypoxia Check oxygen saturation each shift. On 12/9/24 at 3:00 p.m. an interview was conducted with the director of nursing (DON). The DON read the order in R115's clinical record that was written for the oxygen. The DON said, the frequency is missing and would expect the nurses to clarify orders. I think his was continuous, I do know that. I will have to get with the nurse practitioner and see what she wants his oxygen orders to be set at and for us to use. On 12/9/24 at 3:20 p.m., an interview was conducted with R115. R115 stated, I don't wear oxygen during the day. The tank on my wheelchair was used in therapy when I first came here. I only use oxygen at night at 1.5 liters at night and only use the concentrator I don't use this tank anymore at all it is just on my wheelchair. My normal oxygen reading is 93% and most of the time it is reading 93% or higher. On 12/10/24 a review of a facility document was conducted. The facility documentation titled, Infection Control Program, read in part, .development and implementation of written policies and procedures for the prevention and control of infections among residents and personnel. On 12/10/24 at approximately 11:30 a.m., an end of the day meeting was conducted with the administrator and corporate staff to discuss the above concerns. No additional information was provided prior to exit conference.

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Guggenheimer Health and Rehab Center	1902 Grace Street Lynchburg, VA 24504

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for two of twenty-one residents in the survey sample (Residents #105 and #111). The findings include: 1. Resident #105's medications Wellbutrin and midodrine were not available for administration as ordered by the physician. Resident #105 (R105) was admitted to the facility with diagnoses that included heart failure, stroke, coronary artery disease, COPD (chronic obstructive pulmonary disease), hypotension, neuropathy and depression. The minimum data set (MDS) dated [DATE] assessed R105 with moderately impaired cognitive skills. R105's clinical record documented the following physician orders listed with the date ordered. 3/22/24 - Wellbutrin extended release 150 mg two times per day for treatment of depression. 6/12/24 - Midodrine 10 mg three times per day for treatment of hypotension. R105's medication administration record documented the 8:00 p.m. dose of Wellbutrin extended release 150 mg was not administered on 11/28/24. R105's three scheduled doses of midodrine 10 mg were not administered on 12/3/24. R105's clinical record documented a nursing note dated 11/28/24 stating that R105's Wellbutrin was on order from the pharmacy and not available for administration. A nursing note dated 12/3/24 documented concerning R105's midodrine, Medication unavailable. Medication reordered. Omnicell [backup supply] checked; not in stock in omnicell. On 12/9/24 at 4:10 p.m., the registered nurse unit manager (RN #2) caring for R105 was interviewed about the unavailable Wellbutrin and midodrine. RN #2 stated she was not sure why the medications were not available. On 12/10/24 at 10:00 a.m., the director of nursing (DON) was interviewed about R105's unavailable Wellbutrin and midodrine. The DON stated she was not sure if the unavailability of the medications was caused by an ordering discrepancy or poor pharmacy delivery times. The DON stated medications were supposed to be reordered prior to running out and actions taken if medications were not available. This finding was reviewed with the administrator and regional consultants during a meeting on 12/10/24 at 11:05 a.m. with no further information presented prior to the end of the survey. 41449 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For resident #111 (R111), the hydrocortisone tablet was not available for administration as ordered by the doctor. On 12/9/24, a clinical record review was conducted. According to the physician order dated 8/21/24, that remained an active order. The order read, Hydrocortisone Tablet 10 MG, Give 1 tablet by mouth one time a day for adrenal insufficiency. According to the nursing progress notes, R111 was not given a dose on 12/3/24 and 12/4/24, because the medication was not available. On 12/3/24 at 10:09 p.m., the administration note read, on order, not in Omnicell, pharm notified pervious shift per nurse [sic]. The nursing note dated 12/4/24 at 12:12 p.m., read, Medication not given, contacted pharmacy and medication will be delivered this evening. NP notified, no new orders. Resident is aware. On 12/10/24 at approximately 9:30 a.m., the director of nursing was interviewed about R111's medication not being available. The DON explained that when medications are not available the staff are to check the Omnicell [an emergency back-up supply], notify the doctor to see if there are any alternate treatment options available or obtain an order to hold the medication. When asked if an order to hold medication is acceptable in lieu of the facility ensuring medications are in house, the DON said no. On 12/10/24 at 11:10 a.m., during a meeting with the facility administrator and corporate staff, they were made aware of the above findings. No additional information was provided.

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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. 21875 Based on observation, staff interview and facility document review, the facility staff failed to properly store insulin on three out of five medication carts inspected. The findings include: A second-floor medication cart had an unopened insulin pen stored at room temperature and a vial of insulin stored with no date opened indicated on the label. Two medication carts on the third-floor unit had opened insulin pens stored beyond the 28-day limit and unopened insulin pens stored at room temperature. On 12/9/24 at 3:42 p.m., accompanied by licensed practical nurse (LPN) #1, two medication carts on the third-floor unit were inspected. Stored in the cart for rooms 300 to 311 were three Fiasp Flextouch insulin pens for a current resident. The pens had not been opened and had a pharmacy label stating to refrigerate until opened. Also on this cart was a Lyumjev Kwikpen insulin labeled as opened on 10/28/24. The pharmacy label on this pen documented to store at room temperature for 28 days after opening. The medication cart for rooms 312 to 320 had a Humalog Kwikpen insulin for a current resident labeled as opened on 10/21/24. The pharmacy label for this insulin pen stated to use within 28 days once opened. On 12/9/24 at 3:45 p.m., LPN #1 was interviewed about the improperly and out of date insulin stored on the medication carts. LPN #1 stated the unopened insulin was supposed to be kept in the refrigerator until opened. LPN #1 stated the nurse receiving the medication from the pharmacy usually placed insulin pens in the refrigerator. LPN #1 stated the insulin pens opened 10/21/24 and 10/28/24 were beyond the 28-day limit and should have been discarded. On 12/9/24 at 4:00 p.m., the 3rd floor unit manager (LPN #2) was interviewed about the improperly stored insulin on the third-floor carts. LPN #2 stated the nurse receiving medications from the pharmacy was responsible for placing the insulin pens in the refrigerator. On 12/9/24 at 4:15 p.m., accompanied by LPN #3, a medication cart on the second-floor unit was inspected. Stored in this cart was an unopened Lantus Solostar insulin pen. This pen was labeled to refrigerate until opened. Also available on the cart was an opened 10 milliliter vial of Lantus insulin with no date opened indicated on the label/container. The pharmacy label on this vial stated to discard 28 days after opening. LPN #3 stated she was not sure why the unopened insulin pen was stored in the cart. On 12/10/24 at 10:00 a.m., the director of nursing (DON) was interviewed about the improperly stored insulin. The DON stated the nurse receiving the insulin from the pharmacy was supposed to refrigerate the insulin until opened. The DON stated once opened, insulin was supposed to be dated and discarded when beyond the recommended use-by date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Storage of Medications (revised 8/2020) documented, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . Medications and biologicals are stored at their appropriate temperatures and humidity according to the USP [United States Pharmacopeia] guidelines for temperature ranges .Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 [degrees] F .and 46 [degrees] F . These findings were reviewed with the administrator and regional consultants during a meeting on 12/10/24 at 11:05 a.m.

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. 49456 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to assist one resident, Resident #121 (R121) out of a survey of 21 residents, with transportation arrangements to an appointment with radiology services. The findings included: The facility staff failed to assist R121 with transportation to a procedure he had been prepped for at the facility. On 12/9/24 at 2:44 p.m., an interview was conducted with facility's scheduler, OS5. OS5 said, there was some confusion about the appointments, but we didn't know about them. The appointment for September 28th we didn't have a time for the pre surgery, so they had to fax us a time, I do remember that. I remember that the transport driver called off and alternate transport was not available but cannot remember all the details and no note in his record about that appointment on 10/1/24. On 12/10/24 at 9:35 a.m., an interview conducted with OS5. OS5 looked up in R121 clinical record on her schedule and verified that R121 had an appointment on 10/1/24, and orders to be NPO (nothing by mouth) the night prior. OS5 was unable to find anything in her notes about why R121 did not go to the appointment. OS5 called to the radiology department at the hospital and had them on speaker phone for the surveyor to hear, the hospital employee confirmed that R121 didn't show up for his appointment on 10/1/24, and she had no notes about that appointment. On 12/10/24 at 9:40 a.m., an interview was conducted with the transport driver, OS8. OS8 said, I remember I was unable to take [R121 name redacted] to an appointment. When I cannot take them, we try to get another transport or family, but if unable we have to reschedule the appointment. On 12/10/24 at 9:50 a.m., an interview was conducted with the director of nursing (DON). The DON confirmed that R121 had an appointment on 10/1/24 according to his clinical record and that he was prepped for his appointment by being kept NPO the night before his procedure. The DON stated that she was not able to confirm that the appointment that he missed was rescheduled due to no documentation about the appointment was in his clinical record. The DON said, missed appointment you should notify provider, and responsible party, reschedule the appointment, notify provider and responsible party and document. Pretty simple, I think. Rearrange transport if ours is unavailable, we will use other transport. On 12/10/24 a review of facility documentation was reviewed. The facility document titled, Resident Rights, read in part, .the resident has the right to be treated with respect and dignity. The facility document titled, Resident Rights, read in part, .resident has the right to fully informed of, and participate in, his or her treatment. (continued on next page)

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at approximately 11:30 a.m., an end of the day meeting was conducted with the administrator and corporate staff to discuss the above concerns. The regional nurse consultant stated she had called the vascular physician office and that R121 did not have an appointment there on 10/1/24. The surveyor let the regional nurse consultant the appointment was at radiology department, and she said she would investigate it some more. On 12/10/24 at 12:25 p.m., the nurse consultant gave the surveyor some copies of R121 physician notes. Both notes given to the surveyor were dated after R121's appointment date of 10/1/24, one note was dated 10/4/24, and one was dated 10/14/24. The custom information document of R121's visits to the hospital/physicians was just a summary of visits he had made to the hospital and physicians' offices during the year, but this document had no record of missed appointments, it was only a record of visits made by R121. No additional information was provided prior to exit conference.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 49456 Based on observations, resident interviews, staff interviews, and facility documentation review, the facility staff failed to follow the resident food preference for two residents, Resident #103 (R103) and Resident #106 (R106), in a survey sample of 21 residents. The findings included: 1. The facility staff failed to follow the meal ticket and R103's food preference. On 12/9/24 at 12:10 p.m., an observation of the lunchtime meal was conducted. R103's lunch tray was served, according to the meal ticket on his tray, he was supposed to receive salad and soup, neither of those items were present. On 12/9/24 at 12:10 p.m., an interview was conducted with R103 about his lunch meal and meal ticket. R103 stated he was supposed to get soup and salad with two meals every day. R103 said, that generally I will get one or the other and sometimes I don't get either one. On 12/9/24 at 12:15 p.m., an interview was conducted with licensed practical nurse, LPN#5 (LPN5). LPN5 stated that R103 is supposed to have salad and soup on his lunch tray according to the meal ticket. LPN5 stated she would check with the kitchen about the meal ticket and get the items for the resident. 2. The facility staff failed to follow the meal ticket with R106's beverages of choice on the lunchtime meal tray. On 12/9/24 at 12:15 p.m., an observation of the lunchtime meal was conducted. R106's lunch tray was served, and on his ticket, he was supposed to receive hot coffee, fruit punch, and milk. None of those items were present on his lunch tray. On 12/9/24 at 12:20 p.m., an interview was conducted with R106 about his lunch meal and meal ticket. R106 said, I am supposed to get hot coffee because cold coffee isn't good, and I like to get my milk and fruit punch too. Most of the time I don't have anything to drink on my meal trays. On 12/9/24 at 12:25 p.m., an interview was conducted with the certified nursing assistant, CNA#3 (CNA3). CNA3 stated that R106's meal ticket has hot coffee, fruit punch, and milk and these items were not on the lunch tray. CNA3 stated she would go to the kitchen and try to get the items for the resident. On 12/10/24 a review of facility documentation was conducted. The policy titled, Specialized Diets, read in part, .therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. On 12/10/24 at approximately 11:30 a.m., an end of the day meeting was conducted with the administrator and corporate staff to discuss the above concerns. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided prior to exit conference.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41449 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for one resident (Resident #111- R111) in a survey sample of 21 residents. The findings included: 1a. For R111, who saw a dental provider outside of the facility, the facility staff failed to document that the resident attended the appointment and failed to have any documentation of the visit in the resident's clinical record. On 12/9/24 at approximately 2:30 p.m., R111 was visited in the dining room. R111 was noted to be non-verbal but able to nod yes and no to questions. On 12/9/24, a clinical record review was conducted. There was a physician order with a revision date of 11/12/24, that read, Appointment- November 20, 2024 @ 9am Affordable Dentures & Implants. There was no further documentation within the clinical chart to indicate if R111 went to the appointment or not, or if there were any recommendations. On 12/9/24 at approximately 3:45 p.m., an interview was conducted with a registered nurse (RN #2), who was the unit manager. When asked about R111's appointment on 11/20/24, at Affordable Dentures, RN #2 stated that the resident attended the appointment and returned with a written cost estimate for the recommended dental work. RN #2 confirmed that no information was within R111's clinical chart and would have expected nursing to document that the resident went to the appointment and returned. RN #2 was asked to provide the surveyor a copy of the estimate provided by the dental provider. RN #2 stated she would get it for the surveyor the next day. On 12/10/24 at approximately 8:30 a.m., the surveyor did not observe RN #2 on the unit and facility staff confirmed that RN #2 was not at the facility that day. On 12/10/24 at 9:02 a.m., the surveyor met with other employee #5 (OE#5), who makes medical appointments for residents. OE #5 recalled that R111 went to the appointment and said, She went because I was with her and they only paperwork they gave her was the cost of something and I gave it to [RN #2's name redacted]. OE #5 went on to show the surveyor that in a calendar system in the computer, that the surveyor didn't have access to, indicated the appointment was completed. On 12/10/24 at approximately 10 a.m., during a meeting with the director of nursing (DON), when asked about resident appointments, she said, There should be an in and out note [indicating when the resident left and returned], the consults are not always uploaded, or they may not have put the orders in until the in-house provider approves. When asked what the importance of documenting that the resident attended the appointment was, the DON said, if we have an emergency I need to know where they are at. The surveyor asked the DON to provide a copy of the estimate provided regarding recommended services for R111. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 11:04 a.m., during an end of day meeting with the facility administrator and corporate staff they were made aware of the above findings. The surveyor again requested a copy of the estimate for dental services for R111. No additional information was provided prior to conclusion of the survey. 1b. For R111, who had a blood glucose reading of 24 and was not able to be aroused, the nurse administered glucagon twice but failed to enter the standing order into the electronic record of R111, therefore rendering the record incomplete. On 12/9/24, during a clinical record review, it was noted that a progress note entry dated 11/23/24, read, Pt observed clammy and diaphoretic, unable to arouse. Blood sugar check 24 via fingerstick. Emergency dose of Glucagon given from Emergency stock box. Second dose of glucagon given 15 after first, with blood sugar recheck at 37. Pt able to open eyes but remains lethargic and clammy. According to the physician orders for R111 in the electronic health record, the last entry where Glucagon was ordered/administered was on 8/29/22. According to R111's medication administration record, there was no indication that R111 was administered two doses of glucagon on 11/23/24, as indicated in the progress notes. On 12/9/24 at 3:54 p.m., an interview was conducted with a licensed practical nurse (LPN #3). When asked about standing orders, LPN #3 reported that they do have standing orders but when used, they must enter them into the electronic record of the resident. LPN #3 reported that the surveyor could obtain a copy of the standing orders at the nursing station in the provider communication book. On 12/10/24 at 3:37 p.m., an interview was conducted with the facility's director of nursing (DON). The DON stated, standing orders are entered in the computer [electronic record of the resident] as needed [when executed]. On 12/9/24 at approximately 4 p.m., the surveyor looked in the provider communication book and was unable to find a copy of the standing orders. The surveyor made a request to the facility administration to provide a copy of the standing orders. On 12/9/24, the surveyor received the facility's standing orders that read in part, Diabetic Management (Blood Glucose LESS than 70) . If the patient is unresponsive or unable to swallow and does not have a feeding tube: Administer Glucagon 1 mg IM [intra muscular], Repeat BG [blood glucose] after approximately 10 minutes; if <70 and patient is still unresponsive, repeat Glucagon, After giving second Glucagon dose, if patient is still unresponsive, call 911 and notify provider immediately (unless contrary to advance directives), If BG remains ,70 but patient is conscious, initiate interventions for the conscious patient . On 12/10/24 at approximately 9:30 a.m., the above details with regards to R111 being administered glucagon was reviewed with the DON. The DON was asked again about standing orders and said, it has to meet the criteria, and they have to place the order in the computer before they can implement it. If they don't put the order in, then there is no order. On 12/10/24 at 11:04 a.m., during an end of day meeting with the facility administrator and corporate staff, they were made aware of the above findings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49456 Based on staff observation, staff interviews, and facility documentation the facility staff failed to follow infection control standards on one of three units. The findings included: The facility failed to follow the infection control standards regarding glove use, hand hygiene, and transporting of soiled linen in the hallways. On 12/9/24 at 12:15 p.m., a tour of the nursing facility on unit one was conducted. During the tour of unit one, the surveyor observed a certified nursing assistant, CNA#3 (CNA3) transporting dirty linen in the hallway and holding the linen against her body, with gloves on. CNA3 then removed her gloves and began serving lunch trays without performing hand hygiene. On 12/9/24 at 12:25 p.m., an interview was conducted with CNA3. CNA3 said, I didn't know not to carry dirty linen in the hallways or up against my body. I didn't know not to wear gloves in the hallway, and I just forgot to wash my hands. The director of nursing and the floor nurse educated me on gloves and linen in the hallway and to put dirty linen in trash bags earlier this morning. On 12/10/24 at 11:15 a.m., an interview with the director of nursing was conducted. The DON stated that she knew the surveyor heard her educating the staff on unit one yesterday morning about gloves in the hall, transporting of dirty linen and how to wear their surgical mask. The DON stated, she didn't listen. On 12/10/24 a review of facility documentation was conducted. The facility document reviewed was titled, Prevention of Infection - Laundry and Linen, read in part, .all laundry is handled, stored, processed, and transported in a safe and sanitary method. The facility documentation titled, Infection Control Program, read in part, .development and implementation of written policies and procedures for the prevention and control of infections among residents and personnel. On 12/10/24 at approximately 11:30 a.m., an end of the day meeting was conducted with the administrator and corporate staff to discuss the above concerns. No additional information was provided prior to exit conference.