STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675740	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Nursing & Rehab Center Inc	202 Billie Dr Fredericksburg, TX 78624

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to ensure that residents had orders and followed physician's orders for the resident's immediate care for 1 of 13 Residents (Resident #1) reviewed for admission orders. The facility failed to ensure Resident #1's admission orders for insulin administration and blood sugar checks were entered on admission. This failure could place the resident at risk of not receiving necessary care and services upon admission that could result in a deterioration of their condition. Findings included: Record review of Resident #1's face sheet, dated [DATE], reflected he was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus, Resident #1's face sheet did not list his code status. Record review of Resident #1's nursing notes revealed was admitted to the facility after dinner service on [DATE] and expired on [DATE] around midnight. Record review of Resident #1'admission assessment dated [DATE] reflected he had intact cognition. Record review of Resident #1's clinical record revealed a care plan was not available. Record review of Resident #1's physician orders, dated [DATE], did not contain any orders for insulin or blood glucose checks. Record review of Resident #1's hospital discharge summary, dated [DATE], reflected discharge orders for regular insulin ,d+[DATE] U-100 100 unit/mL, 45 units subcutaneous QHS (every night at bedtime) PRN (as needed). The paperwork highlighted the order and showed it was next due at bedtime as needed takes if glucose if greater than 150. Record review of Resident #1's hospital clinicals MAR from [DATE] showed his bedside glucose (reference normal ranges ,d+[DATE]) readings as 307, 380, 136, 133, and 124. The MAR reflected he received insulin twice at the hospital on [DATE] and [DATE]. (continued on next page)

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

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's facility MAR and vitals, dated [DATE], for [DATE] revealed his blood glucose was never checked. During an interview on [DATE] at 12:35 p.m. LVN I stated she did recall Resident #1 had a leg amputation and she obtained his vitals. LVN, I stated resident orders should be put in prior to the residents arrival but stated she was not responsible for putting the orders in the DON at the time would have put in the orders. LVN, I did take the report from the hospital about the resident. LVN, I stated she could not recall if the DON was there during her shift that day. During an interview on [DATE] at 11:41 a.m. attempts to reach the previous DON by phone were unsuccessful. The previous DON resigned from the facility in January of 2024. During an interview on [DATE] at 1:55 p.m. the Administrator stated the resident would come with orders from the hospital. The administrator stated she recalled she spoke to LVN I and asked her what happened with his admission orders. The administrator stated LVN I would have been responsible for putting in Resident #1's admission orders. The administrator stated she did not think the previous DON was there at the time Resident #1 was admitted . Record review of the facility's Medication Administration, policy undated, indicated purpose to accurately prepare, administer and document oral medications .remember any medications that need vital signs taken before being given and take them and hold the medication if necessary .

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review the facility personnel failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 6 residents (Resident #1) whose records were reviewed for code status. Facility staff failed to follow emergency protocol and did not obtain an AED or call emergency services for 25 minutes after Resident #1, who had a Full Code in place, was found unresponsive with no pulse or respirations, according to professional standards of practice. The facility failed to ensure nursing staff had current CPR certification. On 09/05/2024 at 5:01 p.m., and Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/9/2024 at 6:49 p.m., the facility remained out of compliance a severity level of potential for more than minimal harm that was not an Immediate Jeopardy and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk of not receiving life-saving measures, decline in health resulting in serious injury and or death. The findings included: Record review of Resident #1's face sheet, dated 09/04/2024, reflected she was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses to include acute osteomyelitis of right ankle and foot (infection of the bone), type 2 diabetes mellitus, hypercholesterolemia (a disorder known for an excess of low-density lipoprotein (LDL) in your blood), ischemic cardiomyopathy (is a condition of the heart resulting from weakened heart muscles), acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (is clotting of blood in a deep vein of an extremity), chronic combined systolic (congestive) and diastolic (congestive) heart failure (syndrome caused by an impairment in the heart's ability to fill with and pump blood.). Resident #1's face sheet did not list his code status. Record review of Resident #1's nursing notes revealed he was admitted to the facility after dinner service on 9/22/23 and passed on 9/23/23 around midnight. Record review of Resident #1's admission assessment dated [DATE] reflected he had intact cognition. Record review of Resident #1's clinical record revealed a care plan was not available. Record review of Resident #1's physician orders, dated 09/04/2024, reflected he had an order for full code with original date 09/22/2023. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing notes late entry dated 9/23/23 at 9:51 a.m. for 9/22/23 at 4:50 p.m. authored by the DON indicated the resident was admitted after a below the knee amputation on 9/20/23 and was a full code status. Record review of Resident #1's nursing progress note dated 09/23/2023 at 1:22 a.m., authored by LVN A read as follows was called to resident room. No breathes assess. No pulse. Call out to [hospice company name]. Awaiting call back. DON informed. Record review of Resident #1's progress note dated 09/23/2023 at 1:39 a.m., authored by LVN A read as follows This nurse went to check on resident upon entering noted skin color ashen no respiration no pulse. the time was 12:30 am 9/23/23. CPR initiated with crash cart. At 12:45 am 911 was called and arrived at 0109 am (1:09 a.m.) . DON notified and left message to call back tried multiple times to reach. Also called [Doctor] no answer and unable to leave message voicemail full. Also next of kin .multiple times to return call asap unable to reach. DON was called and left message to call N.H. (nursing home) Also [Administrator] notified. able to reach and report resident condition. EMS called [funeral home] awaiting his arrival. Record review of Resident #1's certificate of death, dated 9/23/23, revealed the cause of death was heart infraction (heart attack), an autopsy was not performed, and the manner of death was natural. During an interview on 09/05/2024 at 11:39 a.m., the LVN A stated she worked night shift 11:00 PM to 7:00 AM. LVN A stated when she showed up for work it was busy with call lights going off form residents. LVA A stated she was working with two other CNA's that night. LVN A stated she found the resident unresponsive at 12:40 a.m. on 09/23/23. She stated she started chest compression by herself. LVN A stated she did compression by herself until she stopped to go to the doorway and yell for an aide. She stated CNA C helped obtain the crash cart and placed the back board under the resident. LVN A stated she did not think to get the AED because she panicked. LVN A stated she then stopped giving compressions around 1:05 a.m., 25 minutes after she found him, to call emergency services. LVN A stated EMS arrived around 1:05 a.m. connected him to machines and stated he was deceased . LVN A stated she thought she had a current CPR certification at the time. LVN A stated night shift was responsible for checking the crash cart nighty and the AED machine monthly. During an observation on 9/04/24 at 11:32 a.m. the crash cart contained 1 ambu bag (a medical tool which forces air into the lungs of patients who have either ceased breathing completely or who are struggling to breathe properly and need additional assistance) that expired on 05/29/2023 and 1 flange tip yankauer with vent (is an oral suctioning tool used in medical procedures. It is typically a firm plastic suction tip with a large opening surrounded by a bulbous head and is designed to allow effective suction without damaging surrounding tissue. The vent allows for control of suctioning) that expired on 07/28/2024. The log for daily checks of the cart was blank for September of 2024. The log to daily checks was last completed on 08/20/24. During an interview on 09/04/2024 at 12:21 p.m., The acting DON, LVN, stated staff was expected to complete the crash cart log every night, the AED log was checked monthly and night shift does the logs. The DON stated staff took a course here with the previous DON but they never got their certificates. The DON stated she had been keeping up with the AED checklist but had not kept up with the crash cart check list. The DON stated when she started at the facility in May of 2024 the AED pads were expired and she replaced them. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of LVN A's CPR certification reflected LVN A had completed an online only course. The certification was completed 10/25/2023 and had no expiration date listed. Record review of staff CPR certification revealed 8 (RN G, LVN A, LVN H, RN K, LVN B, LVN M, LVN I, and LVN J) did not have current BLS CPR certification as of 09/04/2024. Record review of the AED checklist log for 2024 revealed the AED was not check of for the months of 02/2024 and 04/2024. Record review of the crash cart logs, on 9/4/24, revealed to check offs for 09/2023 and 10/2023 were missing. Further review revealed the logs for 11/2023 and 12/2023 were not completed out daily. Record review of an in-service training attendance roster, dated 09/26/2023, titled Emergency Preparedness & Response, reflected the following topics of discussion: *Make sure you are aware of the code status on residents and that they're up to date and easy to locate. *Ensure crash cart is checked daily that it is in working order and all items in stock. *Check the AED battery daily for proper functioning. *If you enter an emergency situation, call for help by yelling, pull the emergency call light in the room, call on phone, etc. *When finding someone unresponsive, begin assessment for breathing and pulse, and call for help then CPR if indicated. *Keep your CPR up to date so you can practice the skills. *Respond to an emergency regarding a patient/resident by treating them first, then call and notify the physician, DON, Administrator, family, etc. *Make sure to do walking rounds at the beginning of the shift and lay eyes on all of your patients/ residents. *Be sure to report any changes in conditions promptly to MD for prevention and early catch of an emergency situation. *Thoroughly review chart and medication orders on new admissions to ensure no concerns, interactions, and/or discrepancies are in place. *Call pharmacy to review any medication questions and/or transferring facility for questions or concerns. *For diabetic patients, ensure blood sugar checks are in place and utilized as well as insulin if indicated. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Ensure oxygen is readily available and in good working order. *Contact Administrator and/or DON for any questions or concerns. The in-service was signed by LVN A. Record review of facility document titled Cardiopulmonary Resuscitation (CPR), dated 2005, indicated the following equipment was needed: cardiac arrest board or hard surface, sphygmomanometer (is a device that measures blood pressure) and stethoscope (a medical instrument for listening to the action of someone's heart or breathing), airway, oxygen, suction machine, disposable CPR mask (medical device used to assist in performing CPR while providing a barrier between the rescuer and the person in need) if available per manufacturer's instructions, face mask with handheld portable positive pressure device if available use per manufacturer's instructions. It listed steps for licensed nurses that included 1. Determine unresponsiveness by tapping urgently shaking the basement and shouting are you OK? .2. If the resident does not respond, call out for help. 3. Delegate a specific individual to check resident care plan for CPR or no CPR order, have individual call paramedics, attending physician and administrative personnel per facility procedure and report back to you as soon as possible. 4 .Start .6. If resident is breathless, perform rescue breathing by gently pinching residents nose shut, using your thumb and index finger. 7. Take a deep breath, put your lips around the residence mouth to create an airtight seal. 8. Delivered 2 full breaths, each lasting 1 to 1 1/2 seconds. 9. Pause the inhale between breaths. 10. Observe the chest rise .11. Allow deflation between breaths .14. If there are no signs of breathing or circulation begin chest compressions . Circulation .6. Place heel of one hand on lower part of resident sternum. With your hands directly on top of the first hand, depressed sternum 1 inch or 1 1/2 inches. 7. With arms straight, elbows lock and shoulders over your hands (over resident sternum closed parentheses, performed 15 compressions at a rate of 80 to 100 per minute. 8. Compress any straight downward motion (do not rock or roll close (1 1/2 to two inches for an adult resident. Maintain contact between resident's chest and your hand at all times to assure correct position. Use equal compressions and relaxation, compress 1 1/2 to two inches straight down keep hands on sternum during upstroke. 9. Repeat cycle of 15 compressions to two breaths, performing 4 cycles before you elevate 10. continue uninterrupted until you are relieved by another person knowledgeable about CPR, emergency life support arrives, a physician pronounces the resident expired or you are able to continue . Record review of facility's policy titled Policy for Use of AED in Facility, no date, stated location: the AED is located in the hall next to the communication station and across from the director of nurses office . on site coordinator: the onsite coordinator is the director of nursing . responsibilities of the onsite coordinator include assuring that the AED is maintained in a state of readiness, that it is documented, that there is a mechanism to assure continued competency of the authorized individuals trained to use the AED. Maintaining readiness: the AED will be checked for readiness after each use and at least once every 30 days if it has not been used in the preceding 30 days. Checks will include the following: 1. Assure that the OK light is visible in the readiness display. 2. Check the expiration date on the electrode packet. If the date has passed, replace. Authorized users: all licensed nurses will successfully complete training within 30 days of hire and will be retrained every two years. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Policy for Emergency Cart, dated 7/2021, stated purpose: to organize and maintain the emergency cart (e-cart) to ensure adequate needed equipment for CPR procedures. Adhered to: Nursing departments and other CPR certified staff. Policy: The DON will ensure the equipment are stocked in the e-cart. The DON contacts the contracted pharmacy for the equipment supplies. The E cart will be located on each floor, hall, unit in the medication prep room where it is accessible and known to all staff. The E cart will be inventoried and restocked after each use and checked at least monthly and documented by nursing staff for pharmacist consultant. Back up emergency supplies should be kept in the Med room. Additional supplies and/ or equipment may not be added to the e-cart. All emergency equipment in the E-cart will be checked monthly by the DON. The E-cart should be locked. Once a month the E-cart should be opened and checked for outdated supplies. Internal and external equipment should be checked by ensuring proper functions of equipment. E-cart checks should be documented on the list maintained on the e-cart. E-carts will be maintained and supplied in accordance with the crash cart minimum requirements list which include respiratory equipment. All nurses should be familiar with the E-cart contents and content locations. The nursing staff will ensure that all appropriate documentation has been completed during emergency procedures. Emergency medication stocks separately in an E-kit by the pharmacist. This kit must be checked monthly for expired drugs. New employees will be oriented to all emergency bags/ kits and procedures, and the training programs would be provided to maintain competence in emergency response. E-cart location, supplies, and emergency procedures shall be reinforced each time during the mandatory in service. All nurses should maintain updated CPR certification. At least two staff who are CPR certified are scheduled at each shift. Procedures: during the emergency situations such as: resident is found unresponsive, no response in neurologic checks, severely injured, excessive bleeding, initiate the nursing assessment along with assigned duty to call 911 or EMS. The charge nurse on that shift is in charge of the emergency procedure, including ensuring the reports are properly given to other agencies and the documentation reflects the actual procedures. During the emergency situation, the charge nurse immediately assigns duties to staff include who calls 911, who brings the emergency supplies to the scene, who initiates CPR, who assists, who calls the family and the attending physician, who writes the notes, where are the notes written and saved, who takes the vital signs, what information will you give EMS and who will prepare this information, who will administer medications, who does the documentation (residents response and nursing procedures), who contacts the administrator and/ or DON (if not present) . This was determined to be an Immediate Jeopardy (IJ) on 09/05/2024 at 5:01 p.m. The Administrator was notified and provided with the IJ template. The following Plan of Removal (POR) was accepted on 09/07/2024 at 6:49 p.m. and indicated the following: The facility needs to take immediate action to ensure nursing staff are trained for emergencies to include CPR and AED and emergency response items are in place. Plan of removal 9/6/2023 DON ADON will have every licensed staff in facility CPR certified by end of 9/6/2024. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON and ADON started training (9/6/2024) 2pm in AED/CPR training what we did after we collected every one's current certifications for CPR, we set up a mandatory in-service for all nursing staff. All nurses and CNAs were in serviced in person and were allowed to demonstrate skills to ADON on how to correctly perform CPR. We also in serviced all nursing staff on the use of AED we had them demonstrate to ADON how to fully use the AED machine as well as to where it is always located. Nursing staff were able to properly demonstrate to ADON DON proper use of both AED and crash cart location use of and items were identified in crash cart and demonstrated to nursing staff. As of 9/6/2024 crash cart will be revised nightly per night shift nurse, there is a current log that we implemented (9/6/2024) in a binder in nurses station night shift nurses were shown where to keep binder for nightly check off crash cart. ADON will check log once a week and sign off on log once checked that week. Administrator to review these logs at the end of month every month to ensure compliance. Safety checks were performed in person per [Administrator] to ensure the safety of our residents on the following resident: [Residents # 2-9]all residents voiced no complaints while interview performed per Admin all residents voiced feeling safe in facility. On 9/6/2024 We implemented all nursing staff be current with CPR status I was able to obtain all nurses current CPR cards as attached deadline for them per facility was end of day 9/6/2024 all nurses were able to obtain certs. A few nurses already had certs in place those who did not obtained as per new guidelines. On 9/6/2024 at 2pm we held an in-house in-service training for all licensed personnel. We had this meeting in the activity room where ADON was able to have nurses demonstrate hands on CPR skills as well as full understanding as to when to initiate CPR. We also touched on the topic of AED location as well as the importance of the devices and crash carts not being occluded or in their assigned place. The AED is in the nurses' station in AED box and the crash cart is by the nurse station all staff in serviced not to move crash cart from assigned place on 9/6/2024 As of 9/6/2024, new implemented mandatory for all licensed personnel to have current status of CPR training and current card demonstrating so. As of 9/6/2024 all PRN staff follow guidelines as mentioned. If card is not in place or expired assigned to keep up with status of current cards has been the business office manager to check licensed personnel file to ensure compliance this duty was delegated to BOM effective 9/6/2024 We did include [CAN D] and [CNA E] in in service to implement importance of CNA role during code to call for help how to call who and when CNAs fully understood their roles by end of in service. All other CNA staff was in serviced per ADON in person setting. This took place the 9/6/2024 ADON stayed in building to receive night CNAs and in service them on CPR and AED. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Our policy states 2 CPR certified staff for each shift we are complying currently we have 2 nurses per shift as well as 1 nurse and 1 CNA current on CPR status for night shift [CNA F]certs are attached CNA As of 9/6/2024 ADON will ensure there is always 2 CPR certified personnel per shift as she is staffing coordinator A mock code was presented per ADON to the following nurses; RN [G], LVN [H], [DON] LVN, LVN [J], [K] RN, CNA [D],CNA [E], LVN [L] on 9/6/2024 at 3:30pm All other nurses that are not mentioned above are PRN nurses and the plan in place is to in service them before any scheduled shift. I have set up a follow up in service for 9/13/2024 at 2pm On 9/06/24 to 9/9/2024 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ after verifying their POR had been initiated and/or completed by: All 11 of 12 nursing staff CPR were verified or completed a hands-on CPR course on 9/9/24. LVN M was unable to attend to CPR training and was removed from the schedule until she completed a hands-on CPR course. Interviews conducted between 9/6/24 to 9/9/24 with 9 full time licensed nurse employees from all shifts. 4 PRN employees were unable to be reached by phone and were not on the schedule. The employees interviewed revealed they had received training from the DON regarding how to perform CPR, how to use the AED, where to obtain the crash cart and use items on the crash cart. A sperate CPR course was given on 9/9/24 to some licensed staff. The licenses nurses were all able to answer the questions correctly, validating understanding of the in-service topic. Record review of a binder title Crash Cart Daily Checklist, dated 9/2024, revealed the following: *Cash cart was checked off on 9/6/24 and initialed by LVN A. *Crash cart was checked off on 9/7/24 and initialed by LVN I. * The AED monthly September maintenance for 2024 was and initialed,. Further review revealed the binder included AED training curricula. How to use the AED safely and appropriately with pictures. AED post incident report. DON weekly check signed by ADON for 9/1/24 - 9/7/24. During an observation on 9/9/24 at 8:00 p.m. all items on the crash cart were replaced and not expired. Record review of a statement dated 9/6/24 indicated Safety checks for the following residents were done in person by the Administrator of [facility name and address] 9/6/2024 at 1:06pm for the following residents [#2-9] spoke to [representative] from [insurance company] [company number] who was calling to check on residents due to knowledge of IJ citation. On 9/6/2024 DON/ADON was observed giving a course to several staff. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-service - Hands on Demonstration of CPR skills & AED equipment (crash cart demonstration, calling for help/CNAs), conducted by ADON and DON. In-service handouts included: Policy for emergency cart (E-Cart) Facility has a total of 12 FT nurses (including the ADON and DON) Signed by 10 nurses. 2 RNS 8 LVNS (including the ADON) 2 RNs attended via Skype (including the DON and a PRN nurse) 1 LVN attended via Skype. Signed by 4 out of 6 CNAs. Record review of the facility's policy stated Personnel have completed training on the initiation cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, victims of sudden cardiac arrest. RN's and LVNs will be required to be CPR certified upon hire date. There will be at least 1 CPR certified RN/LVN on duty per shift per day. During an interview on 9/9/24 at 5:22 pm the BOM said she was responsible for ensuring the LVN and RNs CPR are current on hire, annually, or when the CPR certificate expires. She stated she had a binder to keep track. Record review of E-Cart policy - said the facility will have 2 CPR certified staff per shift. Interview on 9/9/24 the Administrator said they had updated their CPR policy as of 9/9/24 to say 1 staff per a shift was CPR certified. The Administrator was informed the Immediate Jeopardy was removed on 09/09/2024 at 6:49 p.m. While the IJ was removed the facility remained out of compliance at a severity level of potential harm that was not an Immediate Jeopardy and a scope of pattern, due to the facility was still monitoring the effectiveness of their Plan of Removal.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Nursing & Rehab Center Inc	202 Billie Dr Fredericksburg, TX 78624

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 (RN K) of 13 nurses reviewed for competent nursing care. RN K failed to administer Resident #12's 10-235 mg hydrocodone acetaminophen one hour before or after the scheduled time according to the facility's policy. These deficient practices could places residents at risk of not receiving medications timely . The findings included: Record review of Resident #12's face sheet, dated 9/7/24, revealed an [AGE] year-old female was admitted on [DATE], with diagnosis that included Parkinson's disease with dyskinesia with fluctuations (is a progressive disorder that affects the nervous system and causes tremors, stiffness and slow movement.), migraine without aura (genetically-influenced complex neurological disorder characterized by episodes of moderate-to-severe headache, most often unilateral and generally associated with nausea and light and sound sensitivity.), spinal stenosis (the space inside the backbone is too small. This can put pressure on the spinal cord and nerves that travel through the spine), and psychotic disorder with hallucinations due to know psychological condition. Record review of Resident #12's MDS, dated [DATE], revealed the resident cognition was severely impaired. Record review of Resident #12's physician orders, dated 9/7/24, revealed the resident received the following medications: *10-235 mg hydrocodone acetaminophen, give 1 tablet by mouth four times a day for pain, with a start date of 5/6/24, and no end date. Record review of Resident #12's Medication Audit Report dated 9/5/24, revealed RN K administered 10-235 mg hydrocodone acetaminophen at the following times: 8/31/24 *9:34 a.m. scheduled for 8:00 a.m. *1:30 p.m. scheduled for 12:00 p.m. *6:03 p.m. scheduled for 4:00 p.m. *7:03 p.m. scheduled for 8:00 p.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/1/24 *9:46 a.m. scheduled for 8:00 a.m. *12:55 p.m. scheduled for 12:00 p.m. *6:48 p.m. scheduled for 4:00 p.m. *7:08 p.m. scheduled for 8:00 p.m. During an interview on 9/6/24 at 11:37 a.m. RN K stated she worked weekends at the facility. RN K stated many times she was too busy with residents and administering medications would pass medications to 2 or 3 residents before she documented in the MAR. RN K stated she kept a cheat sheet of what residents took what medications and wrote residents names on the medication cups. RN K stated she would put a check mark on her cheat sheet to remember she passed their medications. RN K stated she would try to give Resident #12 her 8 p.m. dose of hydrocodone before she put her to bed so she does not wake her up later. RN K stated she got sidetracked documenting the 4:00 p.m. dose she gave before dinner, documented it at 6:30 p.m., and failed to change the administration time. RN K stated the facility policy was to administer medications one hour before or after the ordered time. RN K stated if she was to administer the dose of hydrocodone too close together the resident could experience drowsiness, decreased respiration, low blood pressure, and could require naloxone (medicine that rapidly reverses opioid overdose). During an interview on 9/7/24 at 3:15 p.m. the DON stated staff should record narcotics in the narcotic count log as soon as they dispensed the medication. The DON stated staff should go room by room, check a resident MAR, then pull the medication, administer the medications to the resident, and document the administration. Record review of the facility's policy titled Narcotic Storage, no date, stated . when a narcotic is given it is immediately signed out or on the narcotic sheet . Record review of the facility's policy titled Medication Administration, no dated, stated purpose to accurately prepare, administer and document oral medications . Procedure .3. Read the label on the medication bottle as it is removed from the cart and check the label to the MAR. 4. Read the label prior to pouring the drug Read the label before returning the bottle to the cart. 7. Verify with MAR that you have poured the correct medicine .9. Document in the mar that medication was either taken or refused by the patient . document medication immediately after it was given . properly identified the resident before giving it to them . Whole tablets that are not clearly scored may not be split in half the pharmacists must be called . make it made one hour before scheduled time and one hour after.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45857 Based on interviews and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and follow a policy to provide pharmacy services in accordance with State and Federal laws or rules of the Drug Enforcement Administration for 4 of 6 residents (Residents #10, 11, 12, and 13) reviewed for pharmacy services. 1. The facility failed to dispense the correct number of pills for Resident #10 per physician orders for diazepam (controlled medication used to treat anxiety, muscle spasms, and alcohol withdrawal). 2. The facility failed to ensure Resident #11 blister pack (packaging used for pharmaceuticals) of ,d+[DATE] mg of hydrocodone acetaminophen (medicine used to relieve moderate to severe pain.) was not tampered with and replaced with a ,d+[DATE] mg hydrocodone acetaminophen by RN K. 3. The facility failed to ensure nursing staff who documented they dispensed ,d+[DATE] mg hydrocodone acetaminophen in the narcotic count log also administered and or documented ,d+[DATE] mg hydrocodone acetaminophen in Resident #13's MAR. 21 of the ,d+[DATE] mg hydrocodone acetaminophen were not accounted for on the MAR in January of 2024. These failures could put residents at risk for pain, anxiety, misappropriation, and drug diversion. Findings included: 1. Record review of Resident #10's face sheet, dated [DATE], revealed an [AGE] year-old female was admitted on [DATE], readmitted on [DATE] with diagnoses that included urinary tract infection (infection of the urinary tract), dementia (memory issues), and cognitive communication deficit. Record review of Resident #10's MDS dated [DATE] revealed the resident cognition was several impaired and she took antianxiety medication. Record review of Resident #10's physician orders dated [DATE], revealed for the following: -1 tablet of 2 mg of diazepam by mouth at bedtime with a start date of [DATE] and an end date of [DATE]. -Give 2 mg of Diazepam by mouth at bedtime with a start date of [DATE] and an end date of [DATE]. Record review of Resident #10's [DATE] MAR reflected the resident received doses of Diazepam 2mg from [DATE] through [DATE] and [DATE] through ,d+[DATE]//24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of controlled substance active medication record of Diazepam for Resident #10, dated [DATE], revealed the facility received 14 tablets of 2 mg diazepam on [DATE] and to take 1 tablet at bedtime. LVN I, LNV M, and RN K signed out 2 tablets of 2 mg Diazepam on [DATE] (these were destroyed/not administered), [DATE], [DATE], [DATE], [DATE], [DATE], and on [DATE]. The order was for 1 tablet of 2mg diazepam to be administered. During an observation on [DATE] at 3:10 p.m. Resident #10's pharmacy label stated they received 14 tablets of 2 mg diazepam. During an interview on [DATE] at 3:10 p.m. LVN I stated she documented how many bubbles are filled on the blister package when it was received and not how many pills are in the package total. LVN I stated the package of diazepam may have been half tabs and therefore she documented she gave 2 pills each time. LVN, I stated there could have been an order change at that time and they should have placed a change of directions sticker on the package. LVN I stated they were probably half tabs or 1 mg tabs but she did not document if they were on the log. During an interview on [DATE] at 3:15 p.m. the DON stated staff should be recording the number of pills they receive from the pharmacy and write down the number of pills they are dispensing each time. The DON stated she was not aware the logs did not match the active orders, but she and the pharmacist did reviews of the logs monthly. 2. Record review of Resident #11's face sheet, dated [DATE], revealed an [AGE] year-old female was admitted on [DATE] with diagnosis that included dementia (memory issues), non-pressure chronic ulcer of right ankle with fat later exposed, and anxiety. Record review of Resident #11's MDS, dated [DATE], revealed the resident cognition was several impaired and she took opioid medication. Record review of Resident #11's physician orders, dated [DATE], revealed an order for ,d+[DATE] mg of hydrocodone acetaminophen give 0.5 tab by mouth every 6 hours as needed for pain with a start date of [DATE]. During an observation on [DATE] at 4:13 p.m. a blister package of ,d+[DATE] mg of hydrocodone acetaminophen for Resident #11 was observed. Pills #25 and #26 had broken seals that had clear tape on them. Pill #25 showed M367 and pill #26 showed M365. The pharmacy label stated a white scored oblong tablet side 1: M365 should be in the package. Record review of Resident #11's controlled substance active medication record of ,d+[DATE] mg of hydrocodone acetaminophen for Resident #11, dated [DATE], revealed directions to take one tablet by mouth every 6 hours with a quantity of 120 pills received. The log documented 60 were received. The medication was last signed out on [DATE] by LVN A. A date of [DATE] was written and crossed out with the words error written twice. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:37 a.m. RN K stated she worked over the weekend and on [DATE] she accidently administered Resident #12 the ,d+[DATE] mg hydrocodone that belonged to Resident #11. She stated Resident #12 was ordered ,d+[DATE] mg of hydrocodone-acetaminophen give 1 tab PO QID for pain. RN K stated she did not verify the name and did not document in the control log when she pulled the medication from the cart. RN K stated she realized at the end of her shift that the count was off for the narcotics, so she took one from resident #12's package of 10 mg hydrocodone and put it into Resident #11's package of 5 mg hydrocodone and taped it closed. RN K stated she only did it to one pill and did not notice or know why there were two pill spaces with broken and taped seals. RN K stated she was distracted and made the mistake. RN K stated she should have verified the pills. RN K stated she should have made a report when she realized her mistake. RN K stated if a resident received a higher dose of hydrocodone they could experience drowsiness, decreased respiration, low blood pressure, and could require naloxone (medicine that rapidly reverses opioid overdose). During an interview on [DATE] at 4:18 p.m. the DON stated she last check the narcotics on the nursing carts 2 weeks ago. The DON stated she did not notice any broken deals on the medication packages. During an interview on [DATE] at 12:12 p.m. LVN L stated she has known RN K to not be ready at the change of shift for them to count the narcotics because she needed to fix them. LVN L stated when they would count the narcotics, they were always accurate, and she never noticed any broken seals so there was no reason to report it to the DON. 3. Record review of Resident #13's face sheet, dated [DATE], revealed a [AGE] year-old female was admitted on [DATE] and readmitted on [DATE] with diagnosis that included type 2 diabetes mellitus and acquired absence of left leg below knee. Record review of Resident #13's MDS, dated [DATE], revealed the resident cognition was intact and she took opioid medication. Record review of Resident #13's MAR dated [DATE], revealed the following orders: *,d+[DATE] mg of hydrocodone acetaminophen give 2 tablets by mouth every 4 hours as needed for pain with a start date of [DATE] and an end date of [DATE]. *,d+[DATE] mg of hydrocodone acetaminophen give 1 tablet by mouth every 4 hours as needed for pain with a start date of [DATE] and an end date of [DATE]. The MAR showed the medications were administered on [DATE], [DATE], twice on [DATE], [DATE], twice on [DATE], and [DATE]. A total of 11 pills (3 administtrations of 2 5 mg tablets and 5 administrations of 1 5 mg tablet for a total of 11 pills). Record review of Resident #13's controlled substance active medication record of ,d+[DATE] mg of hydrocodone acetaminophen for dated [DATE], revealed directions to take one to two tablets by mouth every 4 hours as needed with a quantity of 60 pills received. The log documented 60 were received. Further review revealed the medication was dispensed 32 times between [DATE]-[DATE] by 5 different staff. -[DATE] 2 tablets by LVN O (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by former DON -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by unknown LVN P -[DATE] 2 tablets by unknown LVN P -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] 2 tablets by LVN O -[DATE] 2 tablets by LVN O -[DATE] 1 tablet by LVN I -[DATE] 1 tablet by LVN I -[DATE] 1 tablet by LVN I -[DATE] 1 tablet by LVN I -[DATE] 2 tablets by uknown LVN Q Record review of a statement signed by Resident #13 on [DATE] stated I [Resident #13] have not been given the following medication [,d+[DATE] mg of hydrocodone acetaminophen] in the large quantities that have been documented as having been administered to you. At most, I have asked for, and received, only one tablet every couple of days. Resident #13 was not available for interview as she expired on [DATE]. During an interview on [DATE] at 5:00 p.m. the Administrator stated RN G had brought to her attention that former LVN N had been signing out Resident #13's hydrocodone acetaminophen numerous times. The Administrator stated RN G had notified the previous DON twice before going to the Administrator. The Administrator stated the previous DON never report the drug discrepancies to her. The Administrator stated as soon as she was notified of the concern, she reported it and began an investigation. The Administrator stated they were never able to interview LVN N again or drug test her because she never returned to the facility. The Administrator stated the previous DON had a personal relationship with LVN N and believed that was why she did not report her. The Administrator stated the previous DON had put in her notice to resign and did not return to the facility for the investigation. Record review of the facility's policy titled Narcotic Storage, no date, stated purpose to ensure that all controlled medications are accounted for and properly stored under double lock and key .3. The narcotics inventory is counted every shift with the oncoming licensed nurse . out of the off going licensed nurse . when a narcotic is given it is immediately signed out or on the narcotic sheet .