STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265161	A. Building B. Wing	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilson's Creek Nursing & Rehab	3403 West MT Vernon Springfield, MO 65802

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a bed-hold policy was provided to all residents at time of transfer when staff failed to provide a written bed hold notice at the time of a transfer to two (Resident #108 and #20) of two sampled residents. Facility census was 128. Review of the facility's Bed Hold Policy Guidelines showed the following: -The facility will notify all residents, and/or their representative of the bed hold policy guidelines; -The notification shall be given upon admission of the facility; at the time of transfer to the hospital or leave; and at the time of non-covered therapeutic leave. 1. Review of Resident #108's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) date of 10/16/23, located in the Resident Assessment Instrument (RAI) tab of the Electronic Medical Report (EMR), showed the following: -An admission date of 07/11/23; -Resident had a moderately impaired cognition; -Diagnoses included cerebral palsy (a group of conditions that affect movement and posture), anxiety, and anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells). Review the resident's Progress Note, located in the EMR under the Event tab, showed the following: -On 09/14/23, staff evaluated resident on several occasions during the evening shift on 09/14/23 until about 11:40 P.M., at which time the resident was transported to the hospital via EMS [emergency medical services]. The resident was having difficulty expressing what was bothering or hurting him/her, or what staff could do to make it better. This nurse unable to ascertain what is directly bothering the resident. Staff had repositioned the resident for comfort and staff checked vitals. Discharge summary, face sheet, med [medication] list provided to resident along with brief synopsis of events leading to transfer. Resident left facility with EMS at 11:40 P.M. and staff notified family. Staff will also notify the Director of Nursing(DON)] later this morning. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's EMR showed staff did not document notification of a bed hold notice provided to the resident or resident representative when the resident was sent to the hospital on [DATE]. 2. Review of Resident #20's quarterly MDS, with an ARD date of 10/27/23, located in the RAI tab of the EMR, showed the following: -An admission date of 10/29/20; -Resident's cognition was severely impaired; -Diagnoses included of stroke and Type 2 diabetes mellitus with hyperglycemia (high blood sugar levels). Review of the resident's General Notes, located in the EMR under the Progress Note tab, showed the following: -On 06/19/23, at 12:40 A.M., the resident was still able to press the call light, however staff went in and found the resident not responding. Staff called the nurse who assessed the resident. The resident was awake but unresponsive in speech with audible gurgling sounds heard. Vitals were taken. Resident had weak pulse and pupils were not reactive to light. Staff called the physician and received an order to send resident to hospital. -On 06/19/23, at 12:55 A.M., pertinent documents and notification of transfer filled out sent with resident. Resident was transferred out to hospital via stretcher and left the facility at 12:55 A.M. Resident is self responsible. Staff tried to notify family/friend, but no number was provided on the system. Staff made physician and DON aware. Review of the resident's EMR showed staff did not document notification of a bed hold notice provided to the resident or resident representative when the resident was sent to the hospital on [DATE]. 3. During interviews on 11/28/23, at 12:16 P.M., and on 11/30/23, at 1:43 P.M., the Administrator said they do not provide a bed hold policy if they are taking the resident back. They will just give a transfer notice in these cases.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interviews, the facility failed to ensure a Level 2 PASARR (Pre-admission Screening and Resident Review) screen was completed for one resident (Resident #45) and failed to incorporate recommendations from a Level 2 PASARR into one resident's (Resident #104) overall plan of care. Six residents were reviewed for PASARR. The facility census was 128. Review of the facility's Preadmission Screening and Annual Resident Review (PASARR) Tool, dated 2017 , showed the following: -Intent was to ensure that the facility coordinates with the appropriate, State-designated authority, to ensure that individuals with a mental disorder, intellectual disability or a related condition receives care and services in the most integrated setting appropriate to meet their needs; -Coordination includes: Incorporating the recommendations from the PASARR Level 2 determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. 1. Review of Resident #45's Resident Face Sheet, found in the electronic medical record (EMR) under the Continuity of Care (CCD) Tab, showed the following: -admission date of 12/20/21; -Diagnoses included cerebral palsy (a group of conditions that affect movement and posture), unspecified mood disorder, intellectual disabilities, autistic disorder (developmental disability caused by differences in the brain), and conduct disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 09/21/23, showed the following: -Resident rarely or never understood; -Resident had short and long-term memory problems; -Resident received anti-psychotic medication on a routine basis; -Resident was not exhibiting any behavioral symptoms during the assessment period. Review of the resident's Level 1 PASSAR document, dated 06/18/15, showed the following: -Resident met the federal definition of Intellectual Disability/Related Condition (ID/RC), but does not require specialized services. Please incorporate the lesser intensity services into the resident's care plan; -OBRA (Omnibus Budget Reconciliation Act) and the Department of Health and Senior Services require this letter, the DA-124s and the Level 2 determinations must be sent with the client if transferring to another facility. Review of the resident's PASARR Care Plan, dated 12/29/21, found in the EMR under the Care Plan (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tab, showed the following: -Resident required a Level 2 PASARR Evaluation for admission to the facility; -Interventions included the resident was received behavioral health services; -Resident required a Level 2 PASARR Evaluation due to intellectual disabilities. Review of the resident's record showed staff did not document a Level 2 PASARR completed/received. During an interview on 11/29/23, at 10:40 A.M., the Administrator confirmed the resident's Level 2 PASSAR was not in the resident's record. He expected Level 2 PASARR information should be available in the resident records of anyone qualifying for a Level 2 Evaluation. 2. Review of Resident #104'sResident Face Sheet, undated, found in the EMR under the CCD tab, showed the following: -admission date of 05/12/23; -Diagnoses included major depression, anxiety, and post-traumatic stress disorder (PTSD - psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances). Review of the resident's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/17/23, showed the following: -Cognitively intact; -Resident was not exhibiting any behavioral symptoms during the assessment period. Review of the resident's Physician Order Report, dated 10/31/23 through 11/30/23, found in the EMR under the Orders tab, showed the following: -An active order for Celexa (an antidepressant medication) 40 milligrams (mg) once daily for depression; -An active order for Lamictal (an anti-seizure medication used to treat severe depression) 50 mg daily for severe depression; -An active order for Valium (an anti-anxiety medication) two mg as needed three times daily for anxiety; -An active order for mirtazapine (an anti-depressant medication) 30 mg once daily at bedtime for severe depression. Review of the resident's Level 2 PASSAR document, dated 07/18/23, found in the EMR under the Resident Documents tab, showed the following: -Current diagnoses of PTSD, depressive disorder, anxiety, alcohol abuse, and adjustment disorder; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Symptoms indicated on the document included increased anxiety, increased depression, tearfulness, worry about his/her physical condition, feelings of isolation and being overwhelmed, occasional paranoia, and inability to sleep; -Plan should identify clear steps that will be taken to support individual during a crisis situation, specify who to contact for assistance, how staff should work together with individual during the crisis, as well as to identify when the physician, emergency medical services and/or law enforcement should be contacted. Facility may also wish to utilize (Behavioral Health Crisis Hotline), and Provide for individual personal space, maintain environment with low stimulation, maintain an environment with a minimum of visual/auditory distractions, and establish consistent routines. Review of the resident's Behavioral Health, Psychosocial Well-Being, and Psychotropic Medication Care Plans, dated 11/03/23,found in the EMR under the Care Plan tab, showed staff did not care plan recommendations from the resident's specific level 2 PASSAR. During an interview on 11/29/23, at 10:40 A.M., the Administrator said the recommendations made in the resident's Level 2 PASSAR had not been incorporated into her overall plan of care. He expects any recommendations made in the PASSAR Level 2 evaluation was expected to be incorporated into a resident's overall plan of care.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on facility policy, record review, and staff interviews, the facility failed to ensure a Level 1 PASARR (Pre-admission Screening and Resident Review) was complete for one resident (Resident #24) of six residents reviewed for PASARR. The facility census was 128. Review of the facility's Preadmission Screening and Annual Resident Review (PASARR) Tool, dated 2017, showed the following: -Intent is to ensure that the facility coordinates with the appropriate, State-designated authority, to ensure that individuals with a mental disorder, intellectual disability or a related condition receives care and services in the most integrated setting appropriate to meet their needs; -The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders or intellectual disabilities and related conditions; -The initial pre-screening is referred to as a PASARR Level 1, and is completed prior to admission to a nursing facility. 1. Review of Resident #24's Resident Face Sheet, undated, found in the electronic medical record (EMR) under the Continuity of Care (CCD) Tab, showed the following: -admission date of 07/21/22; -Diagnoses included major depression with psychotic features, obsessive compulsive disorder (OCD - a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both), anxiety, and unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 08/31/23, showed the following: -Moderately cognitively intact; -Receiving anti-psychotic medication on a routine basis; -Not exhibiting any behavioral symptoms during the assessment period. Review the resident's Behavioral Symptoms Care Plan, dated 03/08/21, found in the EMR under the Care Plan tab, showed the following: -Monitor for and intervene as needed if inappropriate behaviors were displayed; -Behaviors were speaking or yelling loudly without realizing it, cursing, and sexually inappropriate behaviors; -Interventions included the resident was being seen by a behavioral health professional as needed for medication management, give medication as ordered, monitor behavior changes, do not argue with (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident, and reinforce the unacceptability of inappropriate behaviors as needed. Review of the resident's Physician Order Report, dated 10/30/23 to 11/30/23, found in the EMR under the Orders tab, showed the following: -An active order for Depakote Sprinkles (a mood stabilizing medication) 250 mg (milligrams) twice daily, for unspecified psychosis not due to a substance or known physiological condition; -An active order for fluvoxamine (an antidepressant medication) 50 mg twice daily for major depressive disorder with severe with psychotic features; -An active order for Seroquel (an anti-psychotic medication) 100 mg once daily and 75 mg once daily for unspecified psychosis not due to a substance or known physiological condition. Review of the resident's record showed staff had not documented completion of a Level 1 PASARR. During an interview on 11/28/23, at 12:12 P.M., the Social Services Director (SSD) confirmed a Level 1 PASARR could not be found for the resident. She said the resident should have had a Level 1 in the record. During an interview on 11/28/23, at 12:20 P.M., the Administrator said a Level 1 PASARR is expected to be in the record. The resident should have had a Level 1 PASARR Screening in the his/her record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record reviews, the facility failed to ensure staff safely turned and repositioned a resident during care, failed to complete fall investigations, and failed to conduct root cause analysis of falls in an effort to identify appropriate intervention to help prevent future falls for one resident (Resident #69) of four sampled residents reviewed for falls. The facility census was 128. Review of the facility's fall prevention manual, dated June 2006, showed the following: -Keep a fall log to analysis causes of falls and facility trends or needs. The data in the log may point to variables that are present when falls commonly occur' -Review the surveillance fall log to make sure the process is working, and falls are being prevented; -The committee should plan interventions individualized for each resident; -When a resident falls, caregivers must conduct an investigation and fill out an incident report, which must provide specific data related to the fall and any injury sustained and identify the probable cause. 1. Review of Resident #69's admission Record, located in the Profile tab of the electronic medical record (EMR), showed the following: -admission date of 12/17/19; -Diagnoses included Alzheimer's disease, shortness of breath, anxiety disorder, restlessness and agitation, and major depressive disorder. Review of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 12/30/19, showed the following: -Resident was at risk for falls related to poor safety awareness; -Keep call light within reach; -Keep pathways free of clutter; -If resident falls, don't get resident until assessed by a licensed nurse; -Assist resident to the restroom before and after meals and at bedtime; -Resident unable to turn and reposition self and required staff assistance; -Staff had not updated the resident's Care Plan since it was implemented on 12/30/19. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed by facility staff), located under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 08/30/23, showed the following: -Resident was rarely understood; -Resident's cognitive ability for daily decision making was severely impaired; -Resident had short- and long-term memory problems; -Resident was dependent on staff for bed mobility, transfers, toileting, and eating. Review of the resident's Event Report, dated 11/20/23, showed the following: -Staff was repositioning the resident so a treatment to his/her buttock could be done. When staff rolled the resident over the resident slid off the bed onto floor, landing on right side of the bed, at 8:15 A.M.; -The resident had a laceration to his/her right eyebrow and steri-strips were applied; -The resident had two small skin tears to his/her left elbow that might have occurred when he/she was moved from off the floor; -Staff notified the resident's family, hospice provider, and physician; -Staff did not document an investigation of the fall. Review of the resident's Care Plan showed staff did not add revisions or interventions related to the fall. During an observation on 11/27/23, at 11:36 A.M., the resident sat in a recliner chair in the dining room. The resident had a large laceration above his/her right eye, with steri-strips in place. During an interview on 11/28/23, at 2:35 P.M., Licensed Practical Nurse (LPN) 1 said the following: -He/she was the nurse that completed the event report on 11/20/23 related to the resident's fall; -The resident's fall occurred on 11/20/23 when he/she along with the assistance of Restorative Nursing Assistant (RNA) 1 was providing care. They had pulled the resident's bed away from the wall while he/she stood on the window side, and RNA 1 stood on the other side, facing the window. They were using the Hoyer lift (mechanical lift) to place the resident in bed and RNA 1 rolled the resident towards him/her and rolled the resident a little too forward towards the side of the bed. The resident rolled off the bed onto the floor. He/she was unable to keep the resident from falling off the bed; -LPN 1 said the Director of Nursing (DON) was on the unit, and they called for her. The DON never discussed the fall or the circumstances of the fall or how the resident rolled off the bed during care; -LPN 1 said he/she never completed any additional training related to turning and repositioning (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the resident's fall; -LPN 1 said he/she observed the resident's mattress seemed firmer on the day the fall occurred, but there had not been any monitoring of the mattress to ensure it remained at the appropriate firmness. He/she did tell the DON he/she noticed the mattress was a little firmer than it normally was, but she was unaware if any changes to the resident's care or any updates to the care plan interventions were ever made because the DON would have handled that. During an interview on 11/30/23, at 9:22 A.M., RNA 1 said the following: -Certified nurse aide (CNA)/RNA staff were able to go into the Kiosk under a resident profile/Care Plan to see what type of care a resident required; -RNA 1 said the resident was a fall risk and required total assistance; -The resident had a recent fall on 11/20/23; -The resident was in a wheelchair in his/her room and he/she, along with LPN 1, were attempting to lay the resident down for wound care; -They used a Hoyer lift to get the resident back into the bed with no issues; -LPN 1 was by the window and RNA 1 was on the outside of the bed. He/she went to roll the resident over in the direction of LPN 1 and the resident rolled off the bed onto the floor; -LPN 1 told him/her to get the DON, so he/she called for the DON. They used a sheet to lift the resident back into the bed and he/she left the room; -The DON never spoke with him/her about the fall and he/she was not asked to write a statement. During an interview on 11/20/23, at 12:37 P.M., Medical Director (MD) 1 said the staff should try to prevent falls since it is part of the care, and he expected staff to investigate all falls. During an interview on 11/30/23, at 1:20 P.M., the DON said the following: -The floor nurse was responsible for completing an Event Report and he/she would review and close it; -She did investigate to identify the root cause of falls, but she did not document that in the medical records or anywhere else; -It was a team effort and falls were discussed during the IDT (Interdisciplinary Team) meeting, along with care plan interventions, and the MDS coordinator would update the care plan; -Staff did not receive any falls training other than what they received during new hire orientation and that was nurse to nurse; -The fall that the resident had on 11/20/23 was not investigated because he/she was told that staff pulled the bed away from the wall and the resident was a little too far over, and the resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rolled off the bed onto the floor; -He/she confirmed there had been no additional training for both staff since the fall occurred. During an interview on 11/30/23, at 2:51 PM, the Administrator said he expected the fall event/investigations to be completed and reviewed for completion.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure monthly medication regimen reviews (MRR) were completed in a timely manner for five of five sampled residents (Residents #104, #33, #34, #90, and #89) reviewed for unnecessary medications. The facility census was 128. 1. Review of Resident #104's Resident Face Sheet, undated, found in the electronic medical record (EMR) under the Continuity of Care (CCD) Tab, showed the following: -admission date of 05/12/23; -Diagnoses included major depression, anxiety, and post-traumatic stress disorder (PTSD- mental health condition that's triggered by a terrifying event - either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 08/17/23, showed the following: -Resident cognitively intact; -Resident was not exhibiting any behavioral symptoms during the assessment period. Review of the resident's Physician Order Report, dated 10/31/23 through 11/30/23, found in the EMR under the Orders tab, showed the following: -An active order for Celexa (an antidepressant medication) 40 milligrams (mg) once daily for depression; -An active order for Lamictal (an anti-seizure medication used to treat severe depression) 50 mg daily for severe depression; -An active order for Valium (an anti-anxiety medication) two mg as needed three times daily for anxiety; -An active order for mirtazapine (an anti-depressant medication) 30 mg once daily at bedtime for severe depression. Review of the resident's record showed the facility's consultant pharmacist had not completed a monthly review of the resident's medication regimen since 08/31/23. There was no documentation in the resident's record to indicate the consultant pharmacist had completed the resident's medication regimen review for the months of September 2023, October 2023, or November of 2023. During an interview on 11/29/23, at 1:06 P.M., the Administrator said the pharmacy consultant was expected to review each resident's medication regimen at least monthly and confirmed the facility had not received any pharmacy reviews for the resident since 08/31/23. The consulting pharmacist was behind on her medication regimen reviews. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/30/23, at 11:50 A.M., the facility's Pharmacy Consultant said she had not provided the facility with any medication regimen reviews for any resident in the facility since 08/31/23. She was expected to review each resident's medication regimen monthly. During an interview on 11/30/23, at 1:08 P.M., the Director of Nursing (DON) said her expectation was medication regimen reviews be completed monthly for each resident. 2. Review of Resident #33's admission Record, undated, located in the EMR under the Admission tab, showed the following: -admission date of 09/04/19; -Diagnoses included dementia, with other behavioral disturbance, altered mental status, anxiety disorder, major depressive disorder, chronic kidney disease (CKD), and type II diabetes mellitus. Review of the resident's quarterly MDS, with an ARD of 09/07/23, located in the EMR under the MDS tab, showed the following: -The resident severely cognitively impaired. Review of the resident's Comprehensive Care Plan, dated 09/11/23, located under the Care Plan tab of the EMR, showed the following: -The resident takes psychotropic medications; -Monitor medications and attempt GDR (gradual dose reduction) as indicated to provide least restricted pharmacological plan and treatment; -Resident to continue to benefit from my psychotropic medications. Review of the resident's Note to Attending Physician/Prescriber, dated 10/31/23, showed the the resident was taking the following psychotropic medications that are due for review: -An order, dated 12/04/20, for Celexa 10 mg po (by mouth) QD (every day) for anxiety; -An order, dated 07/01/23, for Remeron 7.5 mg po for eating disorder; -An order, dated 07/01/23, for Zyprexa 2.5 mg 1/2 tab (1.25 mg) po QD for dementia with behavioral disturbance; -An active order for Xanax (alprazolam) 0.5 mg po Q6H PRN. Review of the resident's Progress Notes, dated 11/29/23, located under the Progress Notes tab of the EMR, showed the Pharmacy Consultant entered medication regimen reviews for the resident on October 2023 as a late entry. During an interview on 11/29/23, at 10:30 AM, the Administrator confirmed the Pharmacy Consultant did not perform timely drug regimen review of medications for the resident. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/30/23, at 11:45 A.M., the Pharmacy Consultant said that she entered the monthly reviews for the months of September, October, and November 2023 on 11/29/23, and the resident's monthly medications regimen review for September and October 2023 were not completed timely. 3. Review of Resident #34's Face Sheet, located in the Profile tab of the EMR, showed the following: -admission date of 06/13/23; -Diagnoses included Alzheimer's disease, vascular dementia with behavior disturbance, anxiety disorder, major depressive disorder, and generalized anxiety disorder. Review of the resident's quarterly MDS, located under the MDS tab of the EMR, with an ARD of 09/18/23, showed the following: -Severe cognitive impairment; -Received antipsychotics on a routine basis. Review of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 06/20/23, showed the following: -Resident received psychotropic medications for Alzheimer's disease, anxiety, and depression; -Administer antipsychotics as ordered and observe/document/report any effects/adverse reactions to doctor. Review of the resident's Physician Orders, located under the Orders tab in the EMR, dated 11/30/23, showed the following: -An order for Seroquel, a psychotropic medication, 50 mg tab twice daily. Review of the resident's EMR showed the last documented MRR on 08/30/23. 4. Review of Resident #90's Face Sheet, located in the Profile tab of the EMR, showed the following: -admission date of 12/24/20; -Diagnoses included Alzheimer's disease, anxiety disorder, and insomnia. Review of the resident's quarterly MDS, located under the MDS tab of the EMR, with an ARD of 09/18/23, showed the following: -Severe cognitive impairment; -Received antipsychotic on a routine basis. Review of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 11/27/20, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	November review yesterday (11/29/23) and sent it to the facility. She said there were no irregularities for Resident #90 and #89 in September and she completed their October and November reviews yesterday (11/29/23). 7. During an interview on 11/30/23, at 1:06 PM the Director of Nursing (DON) said she was the one who reviewed the MRRs and identified that the pharmacy consultant was behind. She expected them to be completed monthly.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on interview and record review, the facility failed to monitor for side effects and target behaviors for three residents (Resident #33, #34, and #104) of five sampled residents reviewed for unnecessary medications and who received psychotropic medications. The facility census was 128. 1. Review of Resident #104 Resident Face Sheet, undated, found in the electronic medical record (EMR) under the Continuity of Care (CCD) Tab, showed the following: -admission date of 05/12/23; -Diagnoses included major depression, anxiety, and post-traumatic stress disorder (PTSD - makes one feel stressed and afraid after the danger is over). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 08/17/23, showed the following: -Cognitively intact; -Resident was not exhibiting any behavioral symptoms during the assessment period. Review of the resident's Physician Order Report, dated 10/31/23 through 11/30/23, found in the EMR under the Orders Tab, showed the following: -An active order for Celexa (an antidepressant medication) 40 milligrams (mg) once daily for depression; -An active order for Lamictal (an anti-seizure medication used to treat severe depression) 50 mg daily for severe depression; -An active order for Valium (an anti-anxiety medication) two mg as needed three times daily for anxiety; -An active order for mirtazapine (an anti-depressant medication) 30 mg once daily at bedtime for severe depression. Review of the resident's Medication Administration Record (MAR), dated 11/01/23 through 11/30/23, found in the EMR under the Orders Tab, showed no documentation to show side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications were being routinely monitored. Review of the resident's Progress Notes, dated 11/01/23 through 11/30/23, showed no documentation of side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications were being routinely monitored. Review of the resident's record showed no documentation to show the risks and benefits of any of the resident's orders psychotropic medication had been reviewed with the resident or that his informed (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consent for the use of the medications had ever been obtained. 2. Review of Resident #33's Face Sheet, undated, showed the following: -admission date of 09/04/19; -Diagnoses included dementia with other behavioral disturbance, altered mental status, anxiety disorder; major depressive disorder, chronic kidney disease (CKD), and type II diabetes mellitus. Review of the resident's quarterly MDS, with an ARD of 09/07/23, located in the EMR under the MDS tab, showed the following: -Severely cognitively impaired; -Did not exhibit any behaviors or moods during the assessment period. Review of the resident's Note to Attending Physician/Prescriber, dated 10/31/23, written by Pharmacist Consultant (PC), showed the resident was taking the following psychotropic medications that are due for review: -An order, dated 01/24/20, for Celexa 10 mg po (by mouth) QD (every day) for anxiety; -An order, dated 07/01/23, for Remeron 7.5 mg po for eating disorder; -An order, dated 07/01/23, for Zyprexa 2.5 mg 1/2 tab (1.25 mg) po QD for dementia with behavioral disturbance; -An active order for Xanax (alprazolam) 0.5 mg po Q6H PRN (every six hours as needed). Review of the resident's Progress Notes, dated 09/08/23, located under the Progress Notes tab of the EMR, showed the most recent behavior monitoring documentation was on 09/08/23. There were no other behavior progress notes documented in the resident's progress notes. Review of the resident's Comprehensive Care Plan, dated 09/13/23, located under the Care Plan tab, showed the following: -Resident to not have signs and symptoms of mood distress as evidenced by verbalizing feeling down, depressed, or hopeless; -Resident will not exhibit signs of isolation (e.g., sad, dull affect, non-communicative, withdrawn, inattention to self-care, etc). 3. Review of Resident #34's Face Sheet, located in the Profile tab of the EMR, showed the following: -admission date of 06/13/23; -Diagnoses included Alzheimer's disease, vascular dementia with behavior disturbance, anxiety disorder, major depressive disorder, and generalized anxiety disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, with an ARD of 09/18/23, located under the MDS tab of the EMR, showed the following: -Severe cognitive impairment; -Resident received antipsychotic on a routine basis. Review of the resident's Care Plan, located under the Care Plan tab of the EMR, dated 06/20/23, showed the following: -Resident taking psychotropic medications for Alzheimer's disease, anxiety, and depression; -Administer antipsychotic as ordered and observe/document/report any effects/adverse reactions to my doctor. Review of the resident's Physician Orders, located under the Orders tab in the EMR, dated 10/20/23, showed the following: -An active order for Seroquel, a psychotropic medication, 50 mg tab twice daily. Review of the resident's Progress Notes, dated 11/01/23 through 11/30/23, showed no documention to show side effects of the resident's psychotropic medication or specific behaviors associated with the administration of the resident's psychotropic medications were being routinely monitored. 4. During an interview on 11/30/23, at 9:45 AM, Registered Nurse (RN) 3 said residents were monitored daily for seven days if there is a change in their medication or if the resident had a new prescription. The RN confirmed that behaviors should be monitored and documented daily. 5. During an interviews on 11/30/23, at 10:00 A.M. and 1:08 P.M., the Director of Nursing (DON) said the following: -If residents did not exhibit any negative behaviors. The facility did not chart because it is time consuming to document every day if there were non-existing behaviors; -The facility had not been aware that the risks and benefits related to the administration of psychotropic medications were to be reviewed with residents receiving psychotropic medications or that specific behaviors and side effects related to the administration of psychotropic medications should be routinely monitored after the first seven days of administration of a medication. 6. During an interview on 11/29/23, at 1:06 P.M., the Administrator said risks and benefits had not been reviewed and informed consent was not being obtained for any residents' use of psychotropic medications. He stated behaviors were tracked for psychotropic medications for seven days after a resident began receiving a new psychotropic medication and behaviors were generally tracked in progress notes. Specific behaviors related to the administration of psychotropic medications for each resident were not being routinely tracked.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on record review, observations, and staff interviews, the facility failed to ensure a medication error rate of less than 5% when staff made three errors out of 30 opportunities, resulting in a 10.00% error rate. The errors involved two residents of five residents (Resident #71 and #124) reviewed for medication administration. The facility census was 128. 1. Review of the directions for use for Miralax showed stir and dissolve into any four to eight ounces of beverage (cold, hot or room temperature) then drink. Review of Resident #71's Resident Face Sheet, undated, found in the electronic medical record (EMR) under the Continuity of Care (CCD) Tab, showed the following; -admission date of 04/10/18; -Diagnoses included constipation. Review of the resident's Physician Order Report, dated 10/30/23 to 11/30/23, found in the EMR under the Orders tab, showed the following: -An active order for Miralax, give 17 grams orally once daily for constipation. Observations on 11/28/23, at 9:19 A.M., showed Certified Medication Technologist (CMT) 1 was observed administering the resident's medication. CMT 1 dissolved 17 grams of Miralax powder in approximately three ounces of water and then administered the medication to the resident. During an interview on 11/28/23, at 9:29 A.M., CMT 1 said he/she was unsure of how much fluid Miralax was to be dissolved in for administration. The CMT checked the directions for use on the side of the Miralax container and said the directions indicated the medication was to be dissolved in four to eight ounces of fluid. During an interview on 11/30/23, at 11:42 A.M., the Pharmacy Consultant said Miralax was expected to be given with at least four ounces of water to be effective and she generally recommended the medication be administered with six to eight ounces of water unless a resident was on a fluid restriction. During an interview on 11/30/23, at 1:02 P.M., the Director of Nursing (DON) said her expectation was that Miralax be given with at least four to eight ounces of fluid. 2. Review of Resident #124's undated Resident Face Sheet, found in the EMR under the CCD tab, showed the following: -admission date of 08/22/23; -Diagnoses included chronic obstructive pulmonary disease (COPD - refers to a group of diseases that cause airflow blockage and breathing-related problems). Review of the resident's Physician Order Report, dated 10/30/23 to 11/30/23, found in the EMR under the Orders tab, showed the following: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An active order for Spiriva (an inhaled medication used to prevent bronchospasm (narrowing of airways in the lungs)) two inhalations daily; -An active order for Symbicort (an inhaled steroid medication used to prevent chronic inflammation in the lungs) two inhalations twice daily. During an interview on 11/30/23, at 11:42 A.M., the Pharmacy Consultant said Spiriva was expected to be administered before Symbicort and there was expected to be a two-minute wait time between inhalations of the same medication and at least a five minute wait time between the administration of two different inhaled medications to ensure effectiveness of the medication. Observations on 11/30/23, at 9:32 A.M., showed CMT 2 was administering the resident's medication. CMT 2 administered the resident's Symbicort first, waiting approximately 10 seconds between the two ordered inhalations of the medication. CMT 2 waited approximately 20 seconds between medications and then administered the resident's Spiriva, waiting approximately 10 seconds between the two ordered inhalations of the medication. During an interview on 11/30/23, at 9:36 A.M., CMT 2 said he/she thought Symbicort should be administered before Spiriva and stated he/she was not aware of any recommended wait time between inhalations of either medication or between the administration of each medication. During an interview on 11/30/23, at 1:02 P.M., the DON said nursing staff was to follow manufacturer's instructions for use with the administration of all medication, including inhaled medication. Non-steroidal medication (Spiriva) was expected to be administered before steroidal medication (Symbicort).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the kitchen ceiling, walls, floors, appliances, and dishware were clean and in good repair, failed to handle left-overs appropriately, and failed to date foods after opening. This deficient practice had the potential to affect 128 of 128 residents who received meals prepared in the facility's only kitchen. The facility census was 128. Review of the facility policy titled, Basics for Handling Food Safely, dated 08/13, showed the following: -Leftovers- Place food into shallow containers and immediately put in the refrigerator or freezer for rapid cooling; -Hot food should be held at 140 F or warmer; -Cold food should be held at 40 degrees F or colder. Review of the facility guidelines itemized in the Nutrition and Dining Services Manual, dated May 2015, showed the following: -Temperature of refrigerators should be 33 to 40 degrees F; -There should be a thermometer in all refrigerators; -Refrigerators should be cleaned per cleaning schedule (at least daily). Spills should be wiped up immediately; -Walls, doors, vents, and ceiling must be free from chipped and/or peeling paint and must be kept in good repair; -Walls, doors, vents, and ceiling must be washed thoroughly at least twice a year; -Heavily soiled surfaces must be cleaned more frequently. 1. Review of the kitchen's Daily Cleaning Schedule, for the days of 11/26/23 through 11/28/23, showed the following: -The convection oven was not initialed as cleaned; -The range ovens were only initialed as cleaned on 11/28/23; -The walls in the walk-in refrigerator were initialed as cleaned on 11/27/23 and 11/28/23; -The floors in the walk-in refrigerator were initialed as mopped on 11/28/23; -The dishwasher floors were initialed as cleaned 11/26/23, 11/27/23, and 11/28/23; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The dry storage room floor was initialed as cleaned on 11/28/23; -The dish machine rack holders were to be cleaned Tuesday and Saturdays was initialed as cleaned on Tuesday, 11/28/23. Observations and interviews during the kitchen tour on 11/27/23, at 10:33 A.M., and on 11/28/23, at 1:22 P.M., showed the following: -The kitchen's only hand sink was observed with coffee-like liquid in the basin. The Dietary Manger (DM) confirmed coffee was poured in the sink and the sink was used for disposing of such liquids. -The walls, wall boards, pipes, and fixtures in and around the kitchen were observed soiled with dried splatters, dirt, and dust debris buildup, especially in and around the hand sink. The wall board behind the hand sink also contained cereal debris and a small earring; -A fly light trap was observed mounted on the upper wall above the pot rack. The trap and the adjacent wall had an accumulation of dust debris. The confirmed the dust debris -The floor in the dry food storage was observed with large yellow stains, sticky residue, and numerous scuff marks. The DM said she thought the yellow was wax build-up; -The interior of the reach-in refrigerator contained dried spillage and no temperature gauge. The DM said they used to have a temperature gauge inside, so they use the outside gauge. -The walk-in refrigerator contained an open gallon container of milk and a half gallon container of chocolate milk with no open date. The floor in the walk-in refrigerator was noted to be sticky, and the back floor area had a heavy dark build-up of dried spillage with a black substance. The interior walls had a collection of black speckled mold- type substance. The DM said the milk was used within a few days and confirmed they didn't date the milk with an open date; -DM was asked about the walls and the floors. DM said it was on the cleaning schedule; -The floor under the three-compartment sink was noted to have a collection of soap suds and a section of the floor was constructed of concrete. The DM said the suds were from an overflow in the drain; -The convection ovens contained a collection of residues and baked on spillage on the inside. Both convection ovens were observed heavily soiled on the exterior with dried food debris and dried spillage. The range ovens had a heavy build-up of spills and splatters. The DM said the top convection oven did not work and the ovens were on the cleaning schedule. -The walls, pipes, and floors behind the ovens, range, and fryer were heavily coated with a thick layer of grease and food residue. The sides of the range ovens and fryer had an accumulation of food particles stuck to the metal; -The floors in and around the hand sink and throughout the kitchen were observed to be worn and soiled with dark spots, scuffed, and stained. The DM said they had a company scheduled to clean the floors, but they never came; (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The ceiling along the dish machine and the three-compartment sink was observed with pieces of peeling paint hanging off the boxed areas. The DM said the boxed areas contained pipes and they were repaired due to the pipes freezing last winter. Observation and interview on 11/28/23, at 1:39 P.M., the DM said they place the left-over food product in containers straight from the steam table and place them in the freezer. DM pointed to a covered quart size container filled to the top with a gravy-type product on the walk-in freezer shelf. DM confirmed it was gravy. The container of gravy measured 117 degrees Fahrenheit (F). The DM said the gravy was placed in the freezer 30 minutes ago. The DM was asked if she was aware of the requirements of cooling foods fast to prevent bacteria from growing in the center of such containers. DM then poured the gravy into two short/shallow containers and placed them back into the freezer. Observations and interview on 11/28/23, at 1:53 P.M., of the nutrition rooms were showed the B-hall refrigerator was noted to be soiled with a large, dried spillage on the inside. The DM said housekeeping or nursing maintain the cleanliness of the nutrition rooms. The C-hall temperature gauge in the refrigerator was noted to measure 48 degrees F. A quart size container of soy milk was stored in this refrigerator. The DM said she was not sure the gauge was working properly, and she would replace it with a new one. Observations on 11/29/23, at 11:10 A.M., showed a residue build-up of a dark substance on eighteen hard plastic dish machine racks and on the exterior of 30 hard plastic plate lids that were in the clean stacks near the dish machine. Observations and interview on 11/29/23, at 11:18 A.M., of the tray line showed several trays of bowls of mixed fruit and apple sauce were observed sitting at room temperature. The DM measured the mixed fruit at 50 degrees F and the apple sauce at 45.5 degrees F. The temperature of the grilled cheese sandwiches, also observed on the tray line, were not taken. The DM stated the fruit items came straight from refrigeration and they did not use provisions to keep the fruit and apple sauce cold during meal service. During an interview on 11/30/23, at 11:34 A.M., the Registered Dietitian (RD) said he/she has told the DM about the general cleanliness of the kitchen and listed it in her report.