STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	05/01/2025

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GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 4/29/25 through 5/1/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F583, F732, F759, F760, and F880. The facility had a census of 40 and was licensed for 59 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		5/19/25

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

Electronically Signed | 05/19/2025

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F 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents' rights to privacy and confidentiality were maintained when personal care signage was posted on the wall for two (2) of three (3) survey days. Resident #10 and Resident #29. Findings Included: A review of the facility's policy, "Promoting/Maintaining Resident Dignity," dated 10/10/24, revealed, "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity ...Compliance Guidelines: ... 12. Maintain resident privacy ..." A review of the facility's policy, "Resident Rights," dated 2/10/25, revealed, "... The facility will inform the resident ...of his or her rights and all the regulations governing resident conduct and responsibilities during the stay in the facility ... Resident rights. The resident has the right to a dignified existence, self-determination ... 7. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. a. Personal	F 583	1. Immediate action taken for the residents found to have been affected include: On May 1, 2025, all signage containing personal and confidential information was removed from resident #10 and #29 rooms to ensure that their right to dignity and privacy are honored. 2. Identification of other residents having the potential to be affected was accomplished by: On May 1, the Certified Nursing Aide Supervisor performed an audit on all occupied resident rooms monitoring for any signage containing person and confidential information. Resident's #10 and #29 were identified as having the potential for harm. 3. Actions taken and systems put into place to reduce the risk of future reoccurrence include: On May 1, 2025 the Staff Development	

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F 583	Continued From page 2 privacy includes accommodations, medical treatment ...personal care ... b. The resident has a right to secure and confidential personal and medical records ..." Resident #10 On 4/29/25 at 10:00 AM, during an observation, Resident #10 was lying in bed with positioning pillows and wedges. Two (2) signs were posted above the head of the bed and one (1) on the bathroom door. The signs read, "No more than 2 pads on the bed," and "Don't remove pillows or wedges from the room," the latter bearing the Administrator's signature. The resident was non-verbal. On 4/29/25 at 1:29 PM, during a phone interview with Resident #10's family members, both reported they were unaware of the signage on the walls. On 4/30/25 at 9:55 AM, during a follow-up observation, the signage continued to be posted on Resident #10's bathroom door and wall. A record review of Resident #10's "Admission Record" revealed the facility admitted the resident on 9/26/14 with diagnoses including Hypoxia and Traumatic Subdural Hemorrhage without Loss of Consciousness, Subsequent Encounter. A record review of Resident #10's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 3/12/25 revealed he required a staff assessment for mental status assessment which indicated his cognitive skills for daily decision making were severely impaired.	F 583	Nurse conducted an in-service with the Certified Nursing Aide Supervisor on the topic of resident rights with focus on Personal Privacy and Confidentiality of Records. On May 5, 2025. The Staff Development Nurse continued to in-service with the Nurses and Nurses' Aides. The incident of Resident 10 and 29 was taken to the Quality Assurance Committee on May 16, 2025. 4. The following corrective action will be monitored to ensure the practice will not reoccur. On May 1, 2025 the Certified Nursing Aide Supervisor began a weekly audit of all occupied resident's rooms to ensure that Resident's rights are honored. The Certified Nursing Aide Supervisor will continue to conduct weekly audits for 12 weeks. He will keep a log of his findings. Beginning on May 2, 2025, the Medical Record clerk will audit the logs weekly. Beginning May 2, 2025, findings of these logs will be discussed for 12 weeks in the weekly Quality and Performance Improvement Meeting. Beginning in July of 2025, this plan of correction will be monitored quarterly at the Quarterly Quality Assurance Meeting for 6 months.	

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F 583	Continued From page 3	F 583		

Resident #29

On 4/29/25 at 8:16 AM, during an observation, Resident #29 was lying in bed and there were two (2) signs posted above the head of the bed and on the bathroom door reading, "No blood pressures or blood sticks in the left arm."

On 4/29/25 at 1:00 PM, during an interview with Licensed Practical Nurse (LPN) #3, she reported Resident #29 had a dialysis shunt in her left arm and that this was care-planned. Staff were aware not to use the left arm for blood pressures or sticks.

On 4/29/25 at 1:35 PM, during an interview with Resident #29's family member, she stated her mother had a dialysis shunt that was never used and was unaware of the signage posted. She confirmed the facility placed the signs to notify staff not to use the left arm and agreed this information should be in the care plan, not on the walls.

On 4/30/25 at 10:00 AM, during an observation, the signs continued to be posted in Resident #29's room.

A record review of Resident #29's "Admission Record" revealed the facility admitted the resident on 10/18/21 with diagnoses including Unspecified Dementia and Chronic Kidney Disease.

A record review of the "Medication Review Report" revealed Resident #29 had a Physician's Order, dated 5/28/24 for "Graft can be used if needed for dialysis."

A record review of Resident #29's "Quarterly

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F 583	Continued From page 4	F 583		

Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 4/9/25 revealed she had a Brief Interview for Mental Status (BIMS) score of 4, indicating she was severely cognitively impaired.

A record review of the "Care Plan Detail" revealed Resident #29 had an individual care plan for the dialysis port located on the left forearm, with interventions to protect the site and avoid any blood pressures or restrictive items on that limb.

On 4/30/25 at 10:10 AM, during an observation and interview with Certified Nurse Aide (CNA) #2, she confirmed signage in both Resident #10 and #29's rooms included information already documented in the medical record or care plan. She was unsure why certain instructions were posted but confirmed the details pertained to personal care.

On 4/30/25 at 10:30 AM, during an interview with LPN #2, she confirmed Resident #10 had been at the facility for years, was totally dependent, and non-verbal. She was not aware of why signage was posted in the room. She confirmed Resident #29 had a shunt in the left arm, no dialysis, and confirmed the signs for "no blood pressure/sticks" were still posted. She stated the care plan contained this information and signage was unnecessary.

On 4/30/25 at 2:00 PM, during an observation with the Administrator and Director of Nursing (DON), both confirmed the signage contained medical information that should not be posted. The Administrator reported she signed the signage but did not know it was displayed on the walls. The DON stated the signs would be

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F 583	Continued From page 5 removed, and an audit would be completed to remove similar signs from other rooms. Both agreed residents' rights, dignity, and privacy must be honored.	F 583		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		5/19/25

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F 732	Continued From page 6 §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure daily nurse staffing information was posted in a visible and accessible location for two (2) of three (3) survey days. Findings included: A review of the facility's policy, "Nurse Staffing Posting Information," dated 12/17/24, revealed, "...It is the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time... Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides 2. The facility will post the Nursing Staffing Sheet at the beginning of each shift... 3. The information posted will be: a. Presented in a clean and readable format. b. In a prominent place readily accessible to residents, staff, and visitors..." On 4/29/25 at 8:30 AM, during an observation of the facility, there was no staffing posted	F 732	1. Immediate action taken for the residents found to have been affected include: On April 30, 2025, the Staffing Requirements were made accessible to residents, staff and visitors by being displayed in a prominent area. 2. Identification of other residents having the potential to be affected was accomplished by: On May 1, 2025 the census was reviewed by the Staff Development Nurse to determine that a census of 40 out of 40 residents were identified as having the potential to be affected by this deficiency. 3. Actions taken and systems put into place to reduce the risk of future reoccurrence include: On May 1, 2025, the Nursing Home Administrator conducted a one on one in-service with the Staff Development nurse to educate on Requirements of Nurse Staffing Information. On May 5, 2025, the Nursing Home Administrator continued to provide in-servicing on the topic of Requirements of Nurse Staffing Information to the Certified Nursing Aide Supervisor and to the Director of Nursing. This incident was taken to the Quality	

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throughout the building. On a bulletin board outside of the old day room on Hall 200, a sign stated, "Assignment Sheet posted inside of the old day room." Inside the conference room, the monthly schedule was posted in a glass case, and the Certified Nurse Aide (CNA) Assignment Sheet was posted. The Assignment Sheet included the date and the assignments of the CNAs only but did not include the facility name, census, or the total number and actual hours worked. It listed four (4) CNAs with room assignments and one (1) shower aide.

On 4/30/25 at 9:00 AM, during an observation there was no posting of the daily staffing. The CNA Assignment Sheet and monthly schedule remained posted in the old day room.

On 4/30/25 at 11:55 AM, during an interview with the Licensed Practical Nurse (LPN) #1/Staff Development Nurse, she explained that she completed the nurse schedule, and the lead CNA completed the CNA schedule. She stated the staffing was posted in the break room/old day room only and included the monthly schedule and the CNA Assignment Sheet. She confirmed that she did not post the staffing information anywhere else.

On 4/30/25 at 12:05 PM, during an interview with CNA #1/Lead CNA Supervisor, he confirmed that he prepared and posted the CNA assignment sheets daily in the old day room. He stated the Assignment Sheet did not include the census, only the names of CNAs and their assignments.

On 4/30/25 at 3:30 PM, during an interview with the Administrator and Director of Nursing (DON), both reported they were unaware that the staffing

Assurance meeting on May 16, 2025.

4. The following corrective action will be monitored to ensure the practice will not reoccur:

On May 1, 2025, the Staff Development Nurse began performing a weekly audit to ensure the Staffing Requirements are made accessible to residents, staff and visitors by being displayed in a prominent area. The Staff Development Nurse will continue to conduct weekly audits for 12 weeks. She will keep a log of her findings. Beginning on May 2, 2025, the Nursing Home Administrator will audit the logs weekly. Beginning May 2, 2025, findings of these logs will be discussed for 12 weeks in the weekly Quality and Performance Improvement Meeting. Beginning in July of 2025, this plan of correction will be monitored quarterly at the Quarterly Quality Assurance Meeting for 6 months.

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F 732	Continued From page 8 was not being posted daily and thought it was posted in the old day room. They confirmed only the CNA Assignment Sheet and the monthly schedule were posted. The DON stated that the Staff Development Nurse was responsible for posting the daily staffing sheet, including all required information, in an accessible area. On 4/30/25 at 3:45 PM, during an interview with LPN #1, she confirmed that she had not been posting the daily staffing in a location visible to all visitors, staff, and residents. She explained that it was done in error because she had simply forgotten. She stated the error would be corrected and the daily staffing sheet would be posted going forward to include all required elements.	F 732		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication error rate of less than five percent (5%) for four (4) of thirty-one (31) observed medication opportunities, resulting in a medication error rate of 12.9%. Findings included: A review of the facility's policy titled, "Medication Administration," revised 2/1/25, revealed, " ...Medications are administered ...in accordance	F 759	1. Immediate action taken for the residents found to have been affected include: On April 30, 2025, Licensed Practical Nurse #4, and the Charge Nurse assessed the resident for adverse affects of the medication error. On May 1, 2025 an order was obtained by the Medical Director to administer Percutaneous Endoscopic Gastrostomy (PEG) medications individually, to ensure Safe administration of medications.	5/19/25

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F 759	Continued From page 9 with professional standards of practice ...Policy Explanation and Compliance Guidelines ...17. Administer medications as ordered in accordance with manufacturer specifications ...c ...Do no crush medications with 'do not crush' instruction ...Example guidelines for Medication Administration (unless otherwise ordered by physician)...Do Not Crush Medications: Crushed meds are not to be combined and given all at once, if via feeding tube ..." A review of the facility's policy titled, "Medication Administration via Enteral Tube," revised 1/20/25, revealed, "It is the policy of this facility to ensure the safe and effective administration of medication via enteral feeding tubes by utilizing best practice guidelines ...Policy Explanation and Compliance Guidelines: 1. Provider pharmacy or consultant pharmacist will be utilized as a resource concerning potential interactions between medications and feeding formulas ...4. Prior to crushing tablets, nurses will consult the "Medications Not to Be Crushed" list ...6. Medications may be combined or added to an enteral feed formula per MD orders ...8. Physician or practitioner documentation will be provided in the medical record stating the medical rational for crushing a medication against a manufacturer's instructions ..." A review of the clinical reference "ISMP (Institute for Safe Medication Practices) Medication Safety Alert, dated 11/17/22, revealed "Preventing errors when preparing and administering medications via enteral feeding tubes ...Common inappropriate administration techniques include: 1) mixing multiple medications together to give at once ...Safe Practice Recommendations ...Seek expertise. Before a prescriber places a	F 759	2. Identification of other residents having the potential to be affected was accomplished by: On May 1, 2025 an audit was completed identifying two residents in the facility receiving medication administration via a PEG tube. The two residents receiving medications, via the PEG tube, were identified as having potential to be affected by this deficiency. 3. Actions taken and systems put into place to reduce the risk of future reoccurrence include: On May 1, 2025 a one-on-one in-service was provided by the Medical Director to the Director of Nursing and to Licensed Practical Nurse #4 on Proper Medication Administration via PEG tubes. On May 5, 2025 the Director of Nursing provided in-service training to all Nurses educating them on Proper Medication Administration, via PEG tubes. This incident was taken to the Quality Assurance meeting on May 16, 2025. 4. The following corrective action will be monitored to ensure the practice will not reoccur: On May 1, 2025, the Charge nurse began performing a weekly audit to ensure the nurses were properly administering PEG tube mediations. The Charge Nurse will continue to conduct weekly audits for 12 weeks. She will keep a log of her findings. Beginning on May 2, 2025, Director of Nursing will audit the logs weekly. Beginning May 2, 2025, findings	

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F 759	Continued From page 10 medication order, and prior to a nurse preparing and administering a medication via an enteral tube, consult a pharmacist with any questions about the safety of a drug to be given via an enteral feeding tube ...Prepare each medication separately. Avoid mixing two or more medications together, whether solid or liquid formulations, as this can create a new unknown entity with an unpredictable release and bioavailability ...Flush ... flush the tube with at least 15 mL (milliliters) of water ...before and after the administration of each medication ...Administer separately. Give each medication separately through the feeding tube ..." A record review of the medication administration instructions from Drugs.com revealed for Aripiprazole, "Swallow the regular table whole and do not crush, chew, or break it. Do not split the orally disintegrating tablet," and for Lansoprazole "do not crush or chew tablets." On 4/30/25 at 9:30 AM, during a medication administration observation for Resident #11, Licensed Practical Nurse (LPN) #4 administered Norvasc 2.5 mg (milligrams), aripiprazole (Abilify)15 (mg), Lansoprazole DR (Prevacid)15 mg, and Pro Stat 30 ml. LPN #4 mixed all four (4) medications together in a cup with water and administered them via syringe in the residents Percutaneous Endoscopic Gastrostomy (PEG) tube. A record review of the "Order Summary Report" revealed Resident #11 had a Physician's Order, dated 11/22/2024, for " ...May crush all non-liquid meds together and mix together for administration." There was an order for Pro-state 30 ml per g (PEG) tube, dated 3/21/25,	F 759	of these logs will be discussed for 12 weeks in the weekly Quality and Performance Improvement Meeting. Beginning in July of 2025, this plan of correction will be monitored quarterly at the Quarterly Quality Assurance Meeting for 6 months.	

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Amlodipine Besylate tablet via G-Tube, dated 3/8/2021, Aripiprazole tablet via G-Tube, dated 3/21/25, and Lansoprazole tablet disintegrating via G-Tube, dated 3/21/25.

Review of Resident #11's medical record revealed there was no evidence of individualized assessments or pharmacy review to evaluate the safety or appropriateness of crushing, combining, and administering the medications through the enteral feeding tube.

On 4/30/25 at 1:00 PM, during an interview with LPN #4, she stated that the facility has a "standing order" from the Medical Director allowing all PEG medications to be crushed and mixed for all residents with PEG tubes. She also stated she had never checked for compatibility or consulted a pharmacist to ensure it was safe to do so.

On 4/30/25 at 1:15 PM, during an interview with the Director of Nursing (DON), she confirmed that crushing and combining medications without checking for compatibility "could cause problems" and stated she was aware staff were combining medications per the physician's orders. She also confirmed that the facility had not conducted individualized reviews for PEG tube residents regarding medications being administered together.

On 4/30/25 at 1:30 PM, during an interview with the Medical Director (MD), he stated that he expects the pharmacy to review medications and check for compatibility. He confirmed that the facility asks for standing orders to administer medications together, but he did not know staff were combining all medications for PEG

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F 759	Continued From page 12 administration. On 4/30/25 at 1:45 PM, during an interview with the Consultant Pharmacist, she stated that she has explained to the nurses that safe practice standards for administering medication via PEG require medications to be given individually. She stated no blanket order should replace clinical judgment and individualized review and explained that combining crushed medications can lead to pharmacokinetic changes and tube blockage, especially in high-risk residents. She was aware staff were combining medications due to standing physician orders. On 4/30/25 at 2:00 PM, during an interview with the Administrator, he confirmed that the facility has standing orders to mix and give PEG medications together. He also confirmed that combining crushed medications can lead to pharmacokinetic changes and tube blockage. A record review of Resident #11's "Admission Record" revealed the resident was admitted on 10/14/13 with current diagnoses including Hypertension. A record review of Resident #11's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident's cognition was moderately impaired.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		5/19/25

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F 760	Continued From page 13 medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure medications were administered according to professional standards of practice by crushing and combining all medications into a single dose for administration via Percutaneous Endoscopic Gastrostomy (PEG) tube, without providing a rational for combining the medication or individualized resident needs, for one (1) of three (3) residents reviewed with feeding tubes. (Residents #11). Cross Reference F759 Findings included: A review of the facility's policy titled, "Medication Administration," revised 2/1/25, revealed, " ...Medications are administered ...in accordance with professional standards of practice ...Policy Explanation and Compliance Guidelines ...17. Administer medications as ordered in accordance with manufacturer specifications ...c ...Do no crush medications with 'do not crush' instruction ...Example guidelines for Medication Administration (unless otherwise ordered by physician)...Do Not Crush Medications: Crushed meds are not to be combined and given all at once, if via feeding tube ..." A review of the facility's policy titled, "Medication Administration via Enteral Tube," revised 1/20/25, revealed, "It is the policy of this facility to ensure the safe and effective administration of medication via enteral feeding tubes by utilizing best practice guidelines ...Policy Explanation and Compliance Guidelines: 1. Provider pharmacy or	F 760	1. Immediate action taken for the residents found to have been affected include: On April 30, 2025, Licensed Practical Nurse #4, and the Charge Nurse assessed the resident #11 for adverse affects of the medication error. On May 1, 2025 an order was obtained by the Medical Director to administer Percutaneous Endoscopic Gastrostomy (PEG) medications individually, to ensure Safe administration of medications. 2. Identification of other residents having the potential to be affected was accomplished by: On May 1, 2025 an audit was completed identifying two residents in the facility receiving medication administration via a PEG tube. The two residents receiving medications, via the PEG tube, were identified as having potential to be affected by this deficiency. 3. Actions taken and systems put into place to reduce the risk of future reoccurrence include: On May 1, 2025 a one on one in-service was provided by the Medical Director to the Director of Nursing and to Licensed Practical Nurse #4, on following Professional Standards of practice by crushing and combining all medications into single dose for administration via PEG tube On May 5, 2025 the Director	

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F 760	Continued From page 14 consultant pharmacist will be utilized as a resource concerning potential interactions between medications and feeding formulas ...4. Prior to crushing tablets, nurses will consult the "Medications Not to Be Crushed" list ...6. Medications may be combined or added to an enteral feed formula per MD orders ...8. Physician or practitioner documentation will be provided in the medical record stating the medical rational for crushing a medication against a manufacturer's instructions ..." A review of the clinical reference "ISMP (Institute for Safe Medication Practices) Medication Safety Alert, dated 11/17/22, revealed "Preventing errors when preparing and administering medications via enteral feeding tubes ...Common inappropriate administration techniques include: 1) mixing multiple medications together to give at once ...Safe Practice Recommendations ...Seek expertise. Before a prescriber places a medication order, and prior to a nurse preparing and administering a medication via an enteral tube, consult a pharmacist with any questions about the safety of a drug to be given via an enteral feeding tube ...Prepare each medication separately. Avoid mixing two or more medications together, whether solid or liquid formulations, as this can create a new unknown entity with an unpredictable release and bioavailability ...Flush ... flush the tube with at least 15 mL (milliliters) of water ...before and after the administration of each medication ...Administer separately. Give each medication separately through the feeding tube ..." A record review of the medication administration instructions from Drugs.com revealed for Aripiprazole, "Swallow the regular table whole and	F 760	of Nursing provided in-service training to all Nurses educating them on Proper Medication Administration via PEG tubes. This incident was taken to the Quality Assurance meeting on May 16, 2025. 4. The following corrective action will be monitored to ensure the practice will not reoccur: On May 1, 2025, the Charge nurse began performing a weekly audit to ensure the nurses were following Professional Standards of practice by crushing and combining all medications into single dose for administration via PEG tube. The Charge Nurse will continue to conduct weekly audits for 12 weeks. She will keep a log of her findings. Beginning on May 2, 2025, Director of Nursing will audit the logs weekly. Beginning May 2, 2025, findings of these logs will be discussed for 12 weeks in the weekly Quality and Performance Improvement Meeting. Beginning in July of 2025, this plan of correction will be taken to the Quarterly Quality and Assurance Meeting for six months.	

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do not crush, chew, or break it. Do not split the orally disintegrating tablet," and for Lansoprazole "do not crush or chew tablets."

During a medication administration observation on 4/30/25 at 9:30 AM, Licensed Practical Nurse (LPN) #4 administered Resident #11 the following medications: Norvasc 2.5 mg (milligrams) per peg, aripiprazole (Abilify)15 mg per peg, Lansoprazole DR (Prevacid)15 mg per peg and pro stat 30 milliliters per peg. LPN #4 mixed all four (4) medications together in a cup with water and administered them via syringe in the residents (PEG) tube.

A record review of the "Order Summary Report" revealed Resident #11 had a Physician's Order, dated 11/22/2024, for " ...May crush all non-liquid meds together and mix together for administration." There was an order for Pro-state 30 milliliters per (PEG) tube, dated 3/21/25, Amlodipine Besylate tablet via G-Tube, dated 3/8/2021, Aripiprazole tablet via G-Tube, dated 3/21/25, and Lansoprazole tablet disintegrating via G-Tube, dated 3/21/25.

Record review of Resident #11's medical record revealed there was no evidence of individualized assessments or pharmacy review to evaluate the safety or appropriateness of crushing, combining, and administering the medications through the enteral feeding tube.

During an interview on 4/30/25 at 1:00 PM, LPN #4 stated that the facility has a "standing order" from the Medical Director allowing all PEG medications to be crushed and mixed for all residents with PEG tubes. She also stated she had never checked for compatibility or consulted

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a pharmacist to ensure it was safe to do so.

During an interview on 4/30/25 at 1:15 PM, the Director of Nursing (DON) confirmed that crushing and combining medications without checking for compatibility "could cause problems" and stated she was aware staff were combining medications per the physician's orders. She also confirmed that the facility had not conducted individualized reviews for PEG tube residents regarding medications being administered together.

During an interview on 4/30/25 at 1:30 PM, the Medical Director (MD) stated that he expects the pharmacy to review medications and check for compatibility. He confirmed that the facility asks for standing orders to administer medications together, but he did not know staff were combining all medications for PEG administration.

During an interview on 4/30/25 at 1:45 PM, the Consultant Pharmacist stated that she has explained to the nurses that safe practice standards for administering medication via PEG require medications to be given individually. She stated no blanket order should replace clinical judgment and individualized review and explained that combining crushed medications can lead to pharmacokinetic changes and tube blockage, especially in high-risk residents. She was aware staff were combining medications due to standing physician orders.

During an interview on 4/30/25 at 2:00 PM, the Administrator confirmed that the facility has standing orders to mix and give PEG medications together. He also confirmed that combining

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F 760	Continued From page 17 crushed medications can lead to pharmacokinetic changes and tube blockage. A record review of Resident #11's "Admission Record" revealed the resident was admitted on 10/14/13 with current diagnoses including Hypertension. A record review of Resident #11's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident's cognition was moderately impaired.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		5/19/25

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F 880	Continued From page 18 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 19 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection by not following manufacturer guidelines for cleaning and disinfecting the glucometer for one (1) of two (2) residents observed for blood glucose monitoring, Resident #95. Findings include: A review of the facility's policy, "Blood Glucose Monitoring," dated 2/15/25, revealed, "It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders ... Policy Explanation and Guidelines ... 2. The nurse will perform the blood glucose test utilizing the facility's glucometer as per manufacturer's instruction. 3. The nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy. 4. If possible, glucometers should not be shared between residents, but if this is not possible, the nurse is responsible for cleaning and disinfection of the machine between residents following the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy ..." A review of the facility's policy, "Glucometer Disinfection," revised 7/24/24, revealed, "The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose	F 880	1. Immediate action taken for the residents found to have been affected include: On May 1, 2025 the Infection Control Nurse provided demonstration of proper glucometer sanitation to Licensed Practical Nurse #4 with a proper demonstration in return. 2. Identification of other residents having the potential to be affected was accomplished by: On May 1, 2025 the Medical Records Nurse performed an audit of all residents receiving accu-checks. All residents receiving accu-checks were identified as having potential to be affected by this deficiency. 3. Actions taken and systems put into place to reduce the risk of future reoccurrence include: On May 1, 2025 the Infection Control Nurse provided one-on-one in-servicing to Licensed Practical Nurse #4 on following the manufacturer’s guidelines for cleaning and disinfecting the glucometers. On May 5, 2025 the Infection Control Nurse provided in-service training to all Nurses educating them on the manufacturer’s guidelines for cleaning and disinfecting the glucometers. This incident was taken to the Quality	

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F 880	Continued From page 20 sampling devices to prevent transmission of blood borne diseases to residents and employees ... Cleaning is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic products. Disinfection is a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects. Policy Explanation and Compliance Guidelines 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use. 2. The glucometers will be disinfected with a wipe pre-saturated with an EPA (Environmental Protection Agency) registered healthcare disinfectant that is effective against HIV (Human Immunodeficiency Virus), Hepatitis C and Hepatitis B virus. 3. The Glucometer will be cleaned and disinfected after each use ..." A review of the General Guidelines for use of the "Super Sani-Cloth," dated 2021, revealed, " ...3b. Unfold a clean wipe and thoroughly wet surface 4. Allow treated surface to remain wet for two (2) minutes. Let air dry ..." A record review of the "Order Summary Report" revealed Resident #95 had a physician's order, dated 4/22/25, for Accu-Chek AC (before meals) and HS (bedtime). On 4/30/25 at 11:15 AM, during an observation, Licensed Practical Nurse (LPN) #4 was observed using a glucometer to check Resident #95's blood sugar. After the procedure, she used a Sani wipe disinfectant cloth and rubbed the top of the glucometer for ten (10) seconds. On 4/30/25 at 1:00 PM, during an interview with LPN #4, she confirmed she failed to cleanse the	F 880	Assurance Meeting on May 16, 2025. 4. The following corrective action will be monitored to ensure the practice will not reoccur: On May 1, 20205, the Infection Control Nurse began performing a weekly audit to ensure the nursing staff are following the manufacturer's guidelines for cleaning and disinfecting the glucometers. The Infection Control Nurse will continue to conduct weekly audits for 12 weeks. She will keep a log of her findings. Beginning on May 2, 2025, Director of Nursing will audit the logs weekly. Beginning May 2, 2025, findings of these logs will be discussed for 12 weeks in the weekly Quality and Performance Improvement Meeting. Beginning in July of 2025, this plan of correction will be taken to the Quarterly Quality and Assurance Meeting for six months.	

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glucometer with the Sani wipe for the required two (2) minutes. She stated she was not familiar with the manufacturer's guidelines that required a two (2) minute contact time.

On 4/30/25 at 1:15 PM, during an interview with the Director of Nursing (DON), she stated that all nursing staff had been in-serviced on proper glucometer cleansing. The DON confirmed that the glucometer was shared among residents, and failure to cleanse it properly could lead to the transmission of blood borne diseases. She confirmed the facility did not currently have any residents with a blood borne disease.

On 4/30/25 at 2:00 PM, during an interview with the Administrator, she stated that she expected staff to follow the manufacturer's guidelines for using Sani wipes to prevent infections.

A record review of Resident #95's "Admission Record" revealed the facility admitted the resident on 4/22/25 with diagnoses including Type 2 Diabetes Mellitus.

A record review of Resident #95's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.