STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST , CARRINGTON, North Dakota, 58421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 05/27/25 and concluded 05/29/25. The issues identified by the complainant were found non-compliant with regulatory requirements.	F0000		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, review of facility policy, and staff interview, the facility failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen and 1 of 1 refrigerator on a nursing unit (Prairie Unit). Failure to clean fans in areas where food is stored and prepared, failure to ensure sanitizer test strips are not expired, and failure to store resident cold	F0812	1.The Dietary Manager immediately ordered new sanitizer testing strips and removed the cold packs from the fridge/freezer. The Maintenance Manager immediately cleaned the hood above stove, fans on the condenser units, and the grate in front of the refrigerator. 2.The facility has determined that all residents have the potential to be affected. 3.Corrective action by the Dietary Manager included updating current cleaning checklists to include the cleaning of the hood vent panels, fans on condenser units, and grate on front of the refrigerator door. The Hood Cleaners company continues to service the oven and hood every 6 months. Documentation requirements have been added to the Dietary Check of Sanitizer Solution Form to include the date sanitizer testing strips are opened and the date in which they expire. Signage has also been posted on the refrigerator on Prairie Unit indicating that only food items are to be stored in fridge/freezer. Dietary staff were provided with updated forms on 6/18/25 and a dietary meeting has been scheduled for 6/24/25 to discuss the expectations of the cleaning schedule and Dietary Sanitation & Housekeeping Policy. 4.The Dietary Manager or designee will complete random observations of the various areas in the kitchen including the grate on the fridge, fans on the condenser units and hoods of the oven to ensure all are maintained in a sanitary condition. Random observations will be completed weekly X 4, monthly X 3, and quarterly X 3. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed.	06/24/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/29/2025

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F0812 SS = E	Continued from page 1 packs in an area separate from food has the potential for contamination of food and may result in a foodborne illness. Findings Include: The 2022 Food and Drug Administration (FDA) Food Code, Chapter 3 Food, Section 3-305 Preventing Contamination From the Premises, Section 3-305.11 states, "A. . . . Food shall be protected from contamination by storing the food: . . . 2) Where it is not exposed to . . . dust, or other contamination. . . ." Review of the facility policy "Dietary Sanitation and Housekeeping Policy" occurred on 05/29/25. This undated policy, stated, "Goal: To provide all dietary employees with adequate training and education on sanitary requirements . . . and to assure that the requirements are maintained in the storage, preparation, distribution of foods . . . The dietary manager and assistant dietary manager are responsible to monitor sanitary conditions within the dietary department and make corrections and re-education staff as necessary. Cleaning schedules are posted and followed for routine cleaning of all equipment and work areas. Sanitizing solution concentration is periodically checked for adequate dispensing of sanitizer . . ." Observation of the kitchen on 05/27/25 at 12:29 p.m. with an administrative dietary staff member (#14) showed the following: *Quaternary Ammonia Sanitizer test strips, used by staff to test the concentration of sanitizer solution, with an expiration date of December 2023. * An accumulation of dust on the hood above the oven. When asked how often the hood is cleaned, the dietary staff member (#14) stated a company cleans the hood every six months, but did not know when it was last cleaned. * An accumulation of dust/dirt on the grate below the front door of a reach-in refrigerator. * Walk in Cooler with an accumulation of black	F0812		06/24/2025

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F0812 SS = E	Continued from page 2 dust/dirt on a total of four fans located on two separate condenser units. During an interview on 05/27/25 at 10:45 a.m., the administrative dietary staff member (#4) confirmed staff should not use expired sanitizer test strips and should clean the dust/dirt from the exhaust hood, grates, and fans. Observation of the refrigerator/freezer on the Prairie Unit occurred on 05/27/25 at 1:00 p.m. The freezer contained two resident cold packs, used on the body, stored next to food items. During an interview on 05/29/25 at 10:22 a.m. an administrative nursing staff member (#7) confirmed staff should not store resident cold pack in the food freezer and identified a separate refrigerator designated for resident cold packs.	F0812		06/24/2025
F0880 SS = E	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 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	1.The Infection Prevention Nurse immediately in-serviced certified nursing assistants (CNAs #3-#12) on proper hand hygiene procedures. 2.The facility has determined that all residents have the potential to be affected. 3.Nursing staff were in-serviced on 6/17/25 and 6/18/25 on the facilitys policies for Hand Hygiene and Infection Prevention and Control which addresses standards for proper hand hygiene, glove usage, and the disinfecting of equipment. Nursing staff was provided with additional education on hand hygiene with the use of the Project Firstline IPC mini training offered by the ND Health and Human Services. The facility will work on placing disinfectant wipe containers directly onto mechanical lifts as able. We will complete this by 6/27/2025. 4.The Director of Nursing or designee will complete 10 random observations of facility staff weekly X 4, monthly X 3, and quarterly X 3 to ensure facility staff practice infection control standards related to hand hygiene, glove use, and disinfecting equipment. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed.	06/27/2025

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F0880 SS = E	Continued from page 3 (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. §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, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 15 sampled residents (#16, #20, #32, and #40) and 1 supplemental resident (Resident #45) observed	F0880		06/27/2025

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F0880 SS = E	Continued from page 4 during personal cares. Failure to practice infection control standards related to hand hygiene, glove use, and disinfecting equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Golden Acres Manor Infection Prevention and Control Program" occurred on 05/29/25. This policy, revised 05/20/21, stated, ". . . 8. Equipment Protocol: . . . All reusable items and equipment requiring special cleaning or disinfection shall be cleaned in accordance with our current procedures governing the cleaning and disinfecting of soiled or contaminated equipment. . . ." Review of the facility policy titled "Golden Acres Manor Hand Hygiene" occurred on 05/29/25. This policy, dated 11/28/17, stated, ". . . All facility employees will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. . . . Hand hygiene is indicated and will be performed . . . Between resident contacts . . . After handling contaminated objects . . . before applying and after removing personal protective equipment . . . including gloves . . . When, during resident care, moving from a contaminated body site to a clean body site . . . After assistance with personal body functions (e.g. [example] elimination . . .) . . ." - Observation on 05/28/25 at 1:25 p.m. showed two certified nurse aides (CNAs) (#5 and #6) performed hand hygiene, applied gloves, and transferred Resident #16 to bed with a mechanical ceiling lift. One CNA (#6) removed the resident's soiled brief, and without removing her gloves, obtained a clean brief from a drawer in the bedside dresser. Both CNAs (#5 and #6) performed perineal cares, then one CNA (#6) applied the clean brief to the resident. Both CNAs (#5 and #6) removed their gloves, and without performing hand hygiene, applied new gloves, and transferred Resident #16 into the wheelchair with a mechanical ceiling lift. The CNA (#5) placed the oxygen cannula back in the resident's nose. The CNAs (#5 and #6) adjusted the resident's clothing, blanket, and lift sling. The CNAs removed their gloves, performed hand hygiene, and exited the room.	F0880		06/27/2025

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F0880 SS = E	Continued from page 5 The CNAs (#5 and #6) failed to perform hand hygiene after removing gloves and before applying new gloves, and failed to remove gloves and perform hand hygiene before touching other surfaces. - Review of Resident #20's medical record occurred on all days of survey. The current care plan stated, ". . . Potential for impaired skin integrity related to: Pressure ulcer to right shoulder. History of several to sacro-coccygeal area. . . ." Observation on 05/28/25 at 1:36 p.m. showed two CNAs (#3 and #4) provided Resident #20's perineal cares. One CNA (#3) removed her gown/gloves and exited the room without sanitizing her hands. A few minutes later, the CNA gowned/gloved and re-entered the room with a full body mechanical lift. After the CNAs (#3 and #4) transferred Resident #20 into the wheelchair, one CNA (#3) removed her gown/gloves, exited the room without performing hand hygiene, and transported the resident to the lounge. The other CNA (#4) removed her gown/gloves, exited the room with a garbage bag and the mechanical lift, placed the lift in the hallway and the garbage in a bin in the soiled utility room, and then performed hand hygiene. The CNAs (#3 and #4) failed to perform hand hygiene after removing their soiled gloves and prior to exiting the room, and failed to sanitize the mechanical lift after use. - Observation on 05/27/25 at 4:24 p.m. showed two CNAs (#5 and #8) performed hand hygiene, applied gloves, removed the oxygen cannula from Resident #32's nose, and transferred the resident from the recliner to the bed using a mechanical ceiling lift. One CNA (#5) performed perineal care and applied a protective skin cream. The other CNA (#8) removed the soiled brief and applied a new brief. The CNAs removed their gloves, and without performing hand hygiene applied new gloves, and transferred Resident #32 from the bed to the wheelchair using the ceiling lift. The CNAs (#5 and #8) removed their gloves. One CNA (#8) covered the resident with a blanket, tied and removed the garbage bag, performed hand hygiene, and exited the room. The other CNA (#5) placed the oxygen cannula in the resident's nose, adjusted the over the bed table, placed the call light, performed hand hygiene, and exited the room.	F0880		06/27/2025

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F0880 SS = E	Continued from page 6 The CNAs (#5 and #8) failed to perform hand hygiene after removing gloves, before applying new gloves, and prior to touching other surfaces. - Observation on 05/28/25 at 4:15 p.m. showed two CNAs (#11 and #12) provided Resident #40 with perineal cares, adjusted the resident's clothing, removed the heel protector boots, applied shoes, assisted to transfer from the bed to the wheelchair, and covered the resident with a lap blanket. The CNAs failed to perform hand hygiene after completing perineal cares and prior to touching the resident and other items. - Observation on 05/27/25 at 12:10 p.m. showed Resident #45 rested in bed. Two CNAs (#9 and #10) entered the room, performed hand hygiene, and applied gloves. One CNA (#9) provided incontinent bowel movement cares, removed the soiled gloves, applied new gloves, applied a clean brief and a protective skin cream, and placed supplies back into the bedside dresser. The CNA (#9) failed to perform hand hygiene after removing gloves and before applying new gloves and failed to remove soiled gloves and perform hand hygiene prior to touching other surfaces. During an interview on 05/29/25 at 8:38 a.m., an administrative nurse (#7) confirmed she expected staff to perform hand hygiene after removing gloves, before applying new gloves, prior to touching other surfaces, and when exiting the room. The nurse (#7) also confirmed she expected staff to sanitize the lifts prior to the lifts.	F0880		06/27/2025
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by:	F0602	"Past Noncompliance - no plan of correction required"	

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F0602 SS = D	Continued from page 7 Based on record review, review of a facility reported incident (FRI), policy review, and staff interview, the facility failed to ensure residents remained free from misappropriation of funds for 1 of 1 closed record (Resident #52). Failure to protect residents from misappropriation of funds may result in anxiety, mental anguish, and financial loss. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: Review of the facility policy, "Abuse and Neglect Policy and Procedure" occurred on 05/29/25. This undated policy stated, "POLICY: . . . Residents must not be subjected to abuse by anyone, including, but not limited to facility staff . . . DEFINITIONS OF ABUSE: . . . MISAPPOPRIATION OF RESIDENT PROPERTY: Means the deliberate . . . exploitation or wrongful, temporary or permanent use of a resident's belongings or money without resident's consent. . . . " Review of Resident #52's closed medical record occurred on May 28-29, 2025. The Minimum Data Set (MDS), dated 05/26/24, showed severe cognitive impairment. Review of the FRI, dated 07/12/24, identified the family of Resident #52 contacted the facility about a significant amount of money that had been spent from the resident's checking account. The resident told family she bought an item from an employee (#16) for $40.00 and had given the employee a signed blank check for the purchase. The family stated the employee wrote the check for $550.00 and cashed it. The family stated the employee told the resident she had lost the initial check, and the resident then gave the employee (#16) another check for $40.00. The check was later altered to $340.00. The facility obtained photocopies of the checks, which appeared altered. The facility administration contacted the local police department. Facility staff interviewed Resident #52 and the resident and acknowledged buying two items from the employee. Facility staff interviewed the employee (#16) twice. During the initial interview, the employee acknowledged she had sold Resident #52 two items but could not recall what price he/she had charged. When facility staff told the employee the resident has dementia and is	F0602		

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F0602 SS = D	Continued from page 8 considered a vulnerable adult, the employee stated he/she was unaware of that. During a second interview, the employee acknowledged the transactions made with the resident and stated he/she was "not 100% sure" of the amount he/she received, but stated one check was around $500.00 and another check around $400.00 When facility staff asked about the value of the items, the employee (#16) stated he/she did not know and that he/she made the price up. The employee acknowledged the problem and apologized. During an interview on 05/29/25 at 9:30 a.m., an administrative staff member (#15) stated the facility investigated the incident and terminated the employee on 07/12/24. Based on the following information, non-compliance at F602 is considered past non-compliance. The facility implemented corrective actions to ensure the deficient practice does not recur by the following actions: * Immediately placed the employee on suspension * Reported the incident to the ND Department of Health and Human Services * Completed an investigation following the incident * Contacted the police department *Terminated the employee after the investigation	F0602		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F0657	1.Immediate correction for resident #24 included updating the care plan to indicate residents preference for toileting every 3 to 4 hours and as requested. 2.All residents have the potential to be affected by not having updated care plans. 3.A conversation was held between resident #24 and the Director of Nursing on 6/4/2025 to discuss residents toileting preferences. Residents care plan was again changed to indicate his current preferences. An in-service was held on 6/17/25 with	06/23/2025

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F0657 SS = D	Continued from page 9 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and resident and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the residents' current status for 1 of 15 sampled residents (Resident #24). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Golden Acres Comprehensive Care Plan Policy and Procedure" occurred on 5/29/25. This policy, revised January 2023 stated, ". . . The care plan will include: Identified problems, risk factors, strengths, choices, and preferences . . . measurable goals . . . interventions to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . . . the care plan will be periodically reviewed and revised by a team of qualified persons . . . as the resident condition changes . . . if a condition has not resolved within approximately two weeks, or as based on clinical judgement and resident needs, further evaluation will be completed . . ." -Review of Resident #24's medical record occurred	F0657	Continued from page 9 the licensed nurses and MDS nurses responsible for updating care plans. The nurses were reeducated on facility policies on Comprehensive Care Plans and Care Plan Revisions Upon Status Change. A change in process will be implemented to include a tape-recorded handover report provided by floor nurses which will then be listened to daily on weekdays by administrative nurses. Changes of care, resident preferences, and aspects of residents care can then be recognized, monitored and incorporated into the care plan. 4. The Director of Nursing or Designee will complete audits of care plans for 5 residents weekly X 4, monthly X 3, and quarterly X 3 to ensure aspects of care passed on in morning report is incorporated into the care plans. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed.	06/23/2025

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F0657 SS = D	Continued from page 10 on all days of survey. Diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms. The resident's current Minimum Data Set (MDS) indicated intact cognition. During an interview on 5/27/25 at 2:39 p.m., Resident #24 stated staff do not assist him regularly with urinary incontinence cares during the evening and night, and stated he voiced his concerns and asked to be assisted at least every 3-4 hours, and as needed. Review of Resident #24's bowel and bladder documentation for the months of March, April and May 2025, identified check and change times of 11:00 p.m., 2:00 a.m., and 4:00 a.m. Resident #24's current care plan stated, ". . . toileting assistance: Extensive assist with incontinence cares upon demand . . . do not disturb at night . . . change at night upon request . . ." The care plan failed to reflect the resident's preferences for urinary incontinence cares. During an interview on 5/29/25 at 9:00 am, two administrative nurses (#7 and #13) confirmed staff failed to update and individualize Resident #24's care plan.	F0657		06/23/2025
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, review of manufacturer's instructions, and staff interview, the facility failed to ensure staff followed standards of practice for 2 of 9 supplemental residents (Residents #13 and #39) observed during medication administration. Failure to clarify, accurately transcribe, and reconcile new physician's orders (Resident #13) may result in residents receiving the wrong medication and failure to correctly prime an insulin pen (Resident #39) may	F0658	1.Immediate corrective action for resident #13 included clarifying and accurately transcribing her Metoprolol medication order. No immediate corrective action was done for resident #39 as resident was not affected. 2.All residents have the potential to be affected by inaccurate transcription of medications. All residents requiring insulin administration have the potential be affected if insulin pens are not primed correctly. 3.A new policy for Medication Administration was developed and includes a requirement that two licensed nurses be involved in observing new medication orders when entered into the electronic medical record. Licensed nurses will also be required to compare the blister pack of the medication to the order entered onto the EMAR to verify the accurate transcription of the medication. Education was provided to licensed nursing staff at	06/17/2025

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F0658 SS = D	Continued from page 11 result in residents receiving an inaccurate dose of insulin, and/or result in adverse health consequences. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, . . . Carrying Out a Physician's Order. Nurses are expected to analyze . . . medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . ." Page 833, stated, "There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies - it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. . . ." Review of manufacturer's instructions for the "NovoLog Flexpen" occurred on 05/29/25. These instructions, dated 2023, stated, ". . . Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injection of air and to ensure proper dosing: E. Turn the dose selector to select 2 units F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in . . . A drop of insulin should appear at the needle tip. . ." - Observation on 05/28/25 at 7:56 a.m. showed a nurse (#2) prepared medications for Resident #13. The nurse pulled out a medication card labeled "Metoprolol Succinate ER [extended release] 50 mg [milligrams]" from the medication cart. The order in the Medication Administration Record (MAR) showed "Metoprolol Tartrate 50 mg." The nurse (#2) confirmed a discrepancy between the card label and MAR, did not administer the medication, and stated she would follow up on the discrepancy. On 05/28/25 at 9:00 a.m., the nurse (#2) stated the resident has been receiving the correct medication and dose, but confirmed nursing staff failed to clarify the order when it was written and incorrectly	F0658	Continued from page 11 an in-service on 6/17/25 on the Medication Administration and Insulin Pen Policies as well as reeducation on the correct procedure for preparing an insulin pen. Licensed nurses completed a return demonstration on the correct procedure in preparing an insulin pen prior to administration on 6/17/2025. 4.The Director of Nursing or Designee will complete audits on all new physician medication orders weekly X4, monthly X 3, and quarterly X 3 to ensure the signature of two nurses observing orders and appropriate transcribing of orders into the EMAR. The Director of Nursing or Designee will complete observations on four licensed nurses weekly X 4, monthly X 3, and quarterly X 4 to ensure competency in correct priming of insulin pens. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed.	06/17/2025

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F0658 SS = D	Continued from page 12 transcribed the metoprolol as tartrate instead of succinate on the MAR. - Observation on 05/27/25 at 5:30 p.m. showed a staff nurse (#2) prepared Resident #39's insulin pen for administration. The nurse (#2) held the insulin pen horizontally instead of upright when priming the pen. During an interview on 05/29/25 at 10:22 a.m. two administrative staff (#7 and #13), confirmed nursing staff should clarify medication orders when there is a discrepancy.	F0658		06/17/2025
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to assess residents with a history of trauma and identify known triggers for 1 of 2 sampled residents (Resident #16) reviewed for Post-Traumatic Stress Disorder (PTSD). Failure to ensure staff assess residents with PTSD upon admission, identify known triggers, and provide appropriate person-centered treatment/services may result in re-traumatization. Findings include: Review of the facility policy titled "Behavioral Health Services" occurred on 05/29/25. This policy, dated 10/22/18, stated, ". . . all residents receive necessary behavioral health care and services to . . . reach and maintain the highest level of mental and psychosocial functioning. . . . Behavioral health encompasses a resident's whole emotional and mental well-being, which includes . . . the prevention and treatment of . . . trauma or post-traumatic stress disorders. . . . This process includes: . . . Obtaining	F0699	1.No immediate corrective action was taken as resident #16 was not affected. 2.All residents who have experienced a traumatic event and have not had a trauma informed care assessment completed have the potential to be affected. 3.Residents with a diagnosis of PTSD were reviewed on 5/29/2025 by the MDS nurse to ensure a Trauma Informed Care Assessment was completed on admission. Care plans were reviewed and updated as needed by the MDS nurse on 6/2/2025 for everyone with a PTSD diagnosis. The Trauma Informed Care Assessment was revised on 6/4/2025 with additional questions added to inquire about triggers and interventions and then completed with resident #16. A Trauma Informed Care Policy was developed to include a requirement to perform the Trauma Informed Care Assessment on all new admissions to the facility. Licensed nurses and the social worker were educated on 6/17/2025 on the revised Trauma Informed Care Assessment along with the Trauma Informed Care Policy. 4.The Director of Nursing or designee will perform medical record audits of new admissions to ensure the Trauma Informed Care Assessment has been completed. The audit will also include monitoring of care plans to ensure that triggers and interventions which may be indicated on the Trauma Informed Care Assessment are incorporated into the care plan. This will be completed weekly X 4, monthly X 2 and quarterly X 3. Monitoring and further interventions will be put into place if evidence that further education or interventions are needed.	06/17/2025

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F0699 SS = D	Continued from page 13 history . . . regarding mental, psychosocial, and emotional health . . . Care plan development and implementation . . ." Review of Resident #16's medical record occurred on all days of survey. Diagnoses included PTSD. A psychiatry note, dated 11/19/24, identified a history of physical and sexual abuse, and neglect. The care plan identified, ". . . Mood: Alteration in mood and behaviors related to: . . . anxiety, PTSD . . . Current indicators: feeling down, trouble sleeping, feeling tired . . . Observe for any changes in psychosocial/mood state and report to the physician and social worker. . . ." The medical record lacked documentation of an assessment of past traumas, identification of potential triggers, and a trauma care plan. During an interview on 05/28/25 at 4:28 p.m., an administrative nurse (#11) confirmed staff failed to assess Resident #16 for trauma, identify potential triggers, and develop a trauma care plan.	F0699		06/17/2025