STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035146	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Paradise Valley	4065 East Bell Road Phoenix, AZ 85032

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863 Based on clinical record review, resident and staff interviews, and facility policy review, the facility failed to ensure one resident (#25) was treated with dignity and respect by a visitor. The deficient practice has the potential for additional residents to be treated with a lack of dignity and respect. The facility census was 89, and the resident sample was 18. Findings include: Resident #25 was admitted on [DATE] with diagnoses that included, dementia, type 2 diabetes mellitus with hyperglycemia, hemiplegia/hemiparesis related to cerebral infarction. The care plan, initiated on November 18, 2019 revealed the following areas of focus: -Cognitive deficits related to diagnosis of dementia, and history of CVA -Communication: may have barriers to communication related to expressive aphasia Review the June 2024 Medication Administration Record (MAR) revealed change of condition monitoring for mental well-being from June 12, 2024 through June 15, 2024. The progress note dated June 12, 2024 through June 15, 2024, revealed no documentation of behavioral changes or signs of distress. The facility 5-day investigation report dated June 18, 2024 revealed on June 12, 2024, resident #25 was in the 400-station day room reading near the window and another resident (#392) was seated in a wheelchair in front of the television. A staff member heard a visitor of resident #392 state you mother f**ker, I'm going to throw you out the window; and that, the visitor requested that staff come into the day room. The investigation included interviews with the staff who reported that the visitor yelled and cursed at resident #25; and that, the visitor was concerned the other resident's (#392) breasts were exposed and her pants were pulled down. The report indicated that Resident #25 was placed on change of condition monitoring for three days after the incident. Further, the report also included a type written interview with resident #25 conducted during the facility investigation on June 13, 2024. Resident #25 denied putting his hands on the other resident (#392); and stated that he was holding onto his reading material, and that he left the room when the yelling began. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly Minimum Data Set (MDS) dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The assessment also included that the resident had no behaviors identified. An interview was conducted on July 16, 2024 at 10:42 AM, with the Director of Nursing (DON/Staff #12), who stated that staff reported that on June 12, 2024, a visitor was seen walking past the 400-unit nursing station, entered the day room, and immediately returned to the nursing station asking for a nurse. The DON stated that the visitor returned to the day room with the nurse and then yelled and cursed at resident #25. The DON stated that the resident (#392) the visitor was visiting had pants that did not fit well and would often fall down; and that, staff would cover the resident with a blanket, but the resident would remove it. The DON stated that the visitor was immediately removed from the day room and his behavior was discussed with management. The DON stated that the visitor later told the facility that he really did not think that resident #25 did anything to the resident (#392) he was visiting; but, but he was concerned that the resident was not covered appropriately. The DON further stated that there had been no other complaints/concerns regarding resident #25 being inappropriate with other residents. An interview was conducted on July 17, 2024 at 11:12 AM with a Registered Nurse (RN/staff #13) who stated that on June 12, 2024 on the 400-unit, a visitor who seemed angry stated I need someone in this room (referring to the day room at the station) now. The RN stated when she entered the day room, resident #25 was sitting a few feet away from the door reading, and resident (#392) was visiting was sitting in front of the TV with her blanket on the floor. The RN stated that the visitor pointed that the other resident (#392) nipples were exposed. The RN stated that she immediately pulled the other resident's (#392) shirt down and apologized to the visitor. The RN further stated that the visitor reported that resident #25 was touching the other resident (#392); and that, he would throw resident #25 out of the window. The RN stated she asked the visitor not to talk to the residents like that and the visitor told her to get out of his face. The RN stated that a CNA took resident #25 out of the room, and called the supervisor. The RN said that she assessed resident #25 after the incident; and that, she asked resident #25 if he had touched the other resident (#392). The RN said that resident #25 reported that he did not know what happened. The RN further stated that later in the day a CNA reported that resident #25 was very upset about the situation. An interview was conducted on July 17, 2024 at 11:30 AM with a Licensed Practical Nurse (LPN/staff #75) who stated that a visitor of another resident (#392) entered the 400-unit day room, and less than a minute later went back to the nursing station and asked the nurse to get in the room immediately. The LPN stated that the visitor thought that resident #25 had moved the other resident's (#392) clothing. The LPN stated that when she and the RN (staff #12) entered the day room, resident #25 was on the other side of the room day room reading. The LPN stated that when the visitor saw the other resident (#392) exposed, the visitor thought that resident #25 had done it. The LPN stated that the other resident (#392) would play with her clothes and would pull her shirt up and her pants down; and, this was a normal behavior for the other resident (#392) that staff would keep her covered and faced toward the TV. The LPN also stated that resident #25 did not comprehend what was going on, and he was removed from the day room immediately. The LPN stated that the nurses were standing between resident #25 and the visitor. Further, the LPN stated that the next day resident #25 was kind of sad, but did not know why he was sad. The LPN stated that resident #25 did not have the capacity to comprehend but was aware of time/place. However, the LPN said that resident #25 had to be guided. The LPN stated that she had not observed this type of behavior from the visitor previously, and he had always been a really nice guy. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with another LPN (staff #68) conducted on 07/17/2024 at 12:19 PM, the LPN stated that she was the acting nurse supervisor on June 12, 2024, and she spoke with an RN (staff #13) and the visitor regarding the incident that occurred that day. The LPN stated that the RN (staff #13) came to her office with the visitor and reported that the visitor had yelled at, threatened to punch and throw resident #25 out the window. The LPN stated that the visitor told her he was angry because the other resident's (#392) clothes were askew and resident #25 was next to her reading; and that, as soon as resident #25 saw him, resident #25 backed up. The LPN stated that she discussed the incident with the visitor and she thought that he became upset that the other resident (#392) was exposed, but educated the visitor that he cannot threaten patients or staff. The LPN stated that after the incident, the visitor was only allowed to visit with the other resident (#392) in the lobby and not in the unit. The LPN also stated that her previous interactions with the visitor had always been civil, and she would never have thought that he would do that sort of thing. An interview with Social Services (Staff #50) was conducted on July 17, 2024 at 12:26 PM. Staff #50 stated that she met/interviewed resident #25 on June 12, 2024, after the incident; and, the resident told her that he did not feel safe, and that being yelled at felt like s**t. Staff #50 stated that she could not find her documentation in the medical record, but it was included in the 5-day incident report. During an interview with a Certified Nursing Assistant (CNA/staff #71) conducted on July 17, 2024 at 11:04 AM, the CNA stated that he remembered the incident that occurred on June 12 2024 and that the incident was pretty scary. The CNA stated that he was passing meal trays, and saw the visitor of resident #392 flailing his arms around and yelling at resident #25; and that, the visitor was telling resident #25 that he would throw resident #25 out the window. The CNA stated that the other resident (#392) that the visitor was visiting had her breasts and brief exposed. However, the CNA stated that resident #25 was not anywhere near the other resident (#392). The CNA stated that he covered the other resident (#392) to make sure she was not exposed, and removed her from the area. The CNA stated that resident #25 looked confused and scared, his eyes were all big, and he was sitting a good distance from the other resident (#392); and, was not close enough to touch her. The CNA stated that the visitor was removed from the area as soon as possible, and resident #25 was taken to the dining room. The CNA also stated that he never saw resident #25 acted inappropriately with other residents. Further, the CNA stated that there had been previous times when the visitor would speak loudly, and was not nice to staff and the visitor's approach was mean. A facility policy titled, Dignity, revealed that each resident has the right to be treated with dignity and respect. The facility must protect and promote the rights of the resident. A facility policy titled, Resident Rights, revealed that the facility must protect and promote the rights of the resident. The resident has the right to be treated with respect and dignity. A facility policy titled, Abuse Prevention, revealed that it is the policy of the facility to prevent and prohibit all types of abuse and neglect. Ensure the health and safety of each resident with regard to visitor's subject to the resident's rights.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure one resident's (#3) choice regarding advance directives and orders were accurately reflected in the medical record. The deficient practice could result in resident's choices noted being followed. The resident census was 89 and the sample was 18. Findings include: Resident #3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including acute kidney failure, pneumonitis, anxiety, and depression. The advance directive statement form dated [DATE] revealed the resident wanted CPR (cardiopulmonary resuscitation) in the event that he experiences cardiac arrest. The care plan dated [DATE] revealed the resident had an Advance Directives of CPR and was a full code. Goal was that the resident's advance directives will be honored. Interventions included that code status will be reviewed quarterly and as needed. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The advance directive statement form signed by the resident and dated [DATE] included that the resident wanted CPR (cardiopulmonary resuscitation) in the event that he experiences cardiac arrest. In another advanced directive statement form signed by the resident and dated on [DATE], it included that the resident did not want CPR in the event that he experiences cardiac arrest. However, review of provider order recap revealed that the resident had a full code status. Further, the care plan was not revised to reflect the resident's change in advance directives. On [DATE], the resident signed another advance directive statement form indicating that he wanted CPR in the event that he experiences cardiac arrest. An interview was conducted on [DATE] at 11:20 AM with a Licensed Practical Nurse (LPN / Staff #63) who reviewed the medical record and stated that Resident #3 was a Full Code. The LPN said that the resident signed a revised advanced directive choosing DNR on [DATE]. She stated that staff should base code status on the resident's most recent advance directive which was a DNR (Do Not Resuscitate). However, the LPN was no able to find any orders for a DNR or any paper versions of the resident advance directive. The LPN further stated that this situation could result in staff not following a residents' advance directive choice. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/ Staff #12) conducted on [DATE] at 1:42 PM, the DON stated that resident #3 should have been a full code; and, the inconsistencies in the advance directives of the resident had corrected after the issue brought to their attention. Review of a facility policy on Advance Directives and Advance Care Planning, included that residents may revise an advance directive either orally or in writing. With an oral reversal, charting is due immediately, the physician is notified immediately, and immediate notation is made on the care plan, and an immediate entry is made in the medical record. With written reversals, the physician is notified, and the plan is permanently adjusted. The physician must give an order for any changes in the advance directives.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51158 Based on clinical record review, observations, staff interviews, and policy, the facility failed to ensure that a care plan intervention for monitoring medication side effects related to use of an antianxiety medication was implemented for one resident (#60). The deficient practice could result in the resident not receiving the care and services to meet their needs. Findings include: Resident #60 was admitted on [DATE] with diagnoses of dementia, Alzheimer's disease, cerebral infarction, mild neurocognitive disorder, and altered mental status. The active physician order summary included an order to monitor for side effects related to anti-anxiety medications. The care plan revealed dated December 28, 2023 included that the resident used anti-anxiety medication related to anxiety disorder as evidenced by restlessness. The physician order dated December 28, 2023 included to monitor behaviors of restlessness every shift for 14 days; and, to code whether behavior improved, worsened or unchanged. The care plan was revised on January 18, 2024 to include interventions to observe for the occurrence of target behavior, to report as needed any adverse reactions to the medication and to administer the medications as ordered. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], included a Brief Interview for Mental Status with a score of 00 indicating the resident had severe cognitive impairment. A physician order dated June 12, 2024 included for Ativan (antianxiety) 1 mg tablet administered via G-Tube every 8 hours as needed (PRN) for Anxiety as evidenced be (AEB) restlessness for 14 days, starting on June 12, 2024. The orders for Ativan, monitoring for side effects related to its use were transcribed onto the MAR (medication administration review) for June 2024. Review of the MAR for June 2024 revealed that Ativan was administered to the resident on 10 occasions between June 13 and June 24, 2024. However, the MAR revealed that the monitoring for side effects were not documented as completed from June 13 to 24, 2024. The clinical record revealed no evidence that the monitoring for side effects related to the use of Ativan was discontinued or put on hold. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on July 17, 2024 at 1:17 p.m. with the Director of Nursing (DON/staff# 12) who stated that residents should be monitored for behaviors and side effects while taking psychoactive medication such as Ativan. During the interview, the DON reviewed the clinical record and stated that there was an active order for Ativan for resident #60 and the medication was administered to the resident on 10 occasions between Jun 13 and 24, 2024. The DON also stated that the side effect monitoring was not implemented by staff as care planned between June 13, 2024 and June 24, 2024. The DON stated the risk for not following the care planned interventions could result in lack of identifying side effects and effectiveness of the medication and could affect the overall care of the resident. Review of the facility policy titled, Comprehensive Care Plans and Revisions, revealed that the facility will ensure the timeliness of each resident's person-centered, comprehensive care plan and to ensure that the comprehensive care plans reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update and quarterly review assessments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on clinical record review, observations, staff interviews, and policy, the facility failed to ensure that a care plan was revised to include resident-specific nutritional goals for one resident (#76). The deficient practice could result the resident not being involved and not able to make decisions about their care and needs. Findings include: Resident #76 was admitted on [DATE] with diagnoses of acute metabolic acidosis, type 2 diabetes mellitus, unspecified protein-calorie malnutrition, anemia, dysphagia, and chronic kidney disease. The weight on May 03, 2024 was 130 lbs. (pounds) Review of the nutrition care plan initiated on May 03, 2024 revealed the resident had nutritional problems due her medical diagnoses of dysphagia, esophageal stenosis, and cerebrovascular accident; and, had nutritional risks due to suboptimal meal intakes related to decreased appetite, and potential for weight fluctuations/fluid deficit due to fluid shifts due to diuretic medication. Interventions included to report results to physician and follow up as indicated on any signs and symptoms of dysphagia, to provide and serve diet as ordered, monitor intake and record every meal, registered dietician to evaluate and make diet change recommendations as needed, and to weigh and monitor per orders. The goal was that the resident will have no signs and symptoms of aspiration. The admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6 indicating the resident had severe cognitive impairment. The skilled note dated May 6, 2024 included the resident was alert and oriented x 2-3 and was non-compliant with physician orders. A Nutrition Admission Assessment progress note dated on May 6, 2024 revealed the resident was alert and oriented, had swallowing difficulties related to dysphagia, had a weight of 130 pounds; and, was consuming an average of 50% of meals. Per the documentation, interventions included medication pass supplement 4 ounces three times per day and to monitor weight and oral intakes. The weight record on May 9, 2024 was 121.4 lbs. The Nutrition/Dietary Note dated May 9, 2024 revealed that the weight was 121.4 lbs. and the resident had a weight loss of 8.6 lbs. in 1 week. The documentation included that the resident was refusing the medication pass supplement 6 times due to terrible taste; and that, the resident agreed to have supplemental cereal at breakfast and supplemental pudding at lunch and dinner. The care plan was revised on May 9, 2024 to include an intervention to provide and serve supplements as ordered. The care plan did not include any resident-specific goals and desired outcomes related to her nutrition and weight loss. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician note dated May 10, 2024 included that the resident did not have the capacity to make her own decision. The skilled nursing note dated May 13, 2024 included that the resident complaint of nausea and vomiting post breakfast and was administered with an antiemetic medication. The skilled note dated May 20, 2024 included that the resident refused her breakfast, ate her lunch and was compliant with most of her medications. The weight record on May 20, 2024 was 115.8 pounds, which was a 14.2 pound weight loss in 17 days. The order administration note dated May 20, 2024 included that the resident was alert and oriented x 4 and refused SNP pudding (supplement). A Nutrition/Dietary Note dated May 22, 2024 revealed the resident had a weight of 115.8 lbs.; and that, the resident had a 14.2% weight loss in 3 weeks. The documentation included that the resident consumed an average of 35% of meals; 55% average of the SNP pudding and 35% of the SNP cereals. Recommendations included to add the house shakes three times a day for additional 600 kcal (kilo calories/18 g (grams) protein; and to continue to monitor weights and oral intakes. The care plan was revised on May 22, 2024 to include that the weekly weight loss continued and the supplements were increased. However, the care plan did not include resident's goals and desired outcomes related to her nutrition and weight loss. The weight record on June 1, 2024 was 115 lbs. The Nutrition/Dietary note dated June 12, 2024 revealed the resident was on palliative care, had a weight of 115 lbs. and had a significant unplanned weight loss of 15 lbs. in a month. Per the documentation, the resident had an inadequate intake consuming on the average 40% of her meals, had a decreased appetite and refused supplements. Plan included fortified food house shakes three times daily. Further the documentation included that there were no new recommendations at this time. Despite documentation of resident refusal of supplements in the clinical record, the care plan was not revised to include interventions to address this issue; and, the care plan was not revised to include any new or revised resident-specific goals. An interview was conducted on July 18, 2024 at 9:45 a.m. with the Registered Dietician (RD/staff #77), who stated that she was not following resident #76 for any weight loss; and that, a referral for an evaluation would have been appropriate for the resident due to her significant unplanned weight loss. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON/staff #12) conducted on July 18, 2024 at 10:51 a.m., the DON stated that the facility monitors the effectiveness of interventions through IDT (interdisciplinary team) reviews; and, the care plan was discussed weekly in the IDT meeting or daily, and revised if needed. During the interview, a review of the clinical record was conducted with the DON who stated that there was no evidence found in the clinical record that the care plan did not have any resident-specific goals related to the resident's continued weight loss since the resident's admission on May 3, 2024. The DON further stated that the care plan should have been revised to address the weight loss with resident-specific goals. Review of the facility's policy titled, Comprehensive Care Plans and Revisions, dated [DATE], revealed that the facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. According to the procedure section of this policy, the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery, this can include; additional interventions on existing problems, updating goal or problem statements, and adding a short-term problem, goal, and interventions to address a time limited condition.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on review of clinical record review, resident/staff interviews the facility documentation and policy review, failed to ensure a discharge planning based on the assessed needs and goals was in place for one resident (#49). The deficient practice could result in the delay of the resident transfer/discharge to the facility of choice. Findings include: Resident #49 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure (CRF) with hypoxia, dependence of supplemental oxygen, and heart failure. The care plan dated December 21, 2023 included a discharge plan that the resident wished to return home. The communication note dated May 23, 2024 included that the social services director (SSD/staff #50) had a conversation with the resident's family related to a request to transfer to an assisted living (AL). Per the documentation, the family wanted the transfer. An email correspondence dated May 23, 2024 between the SSD (staff #50) and the Director of Marketing (DoM of the assisted living facility (ALF) the resident was going to) revealed that the planned discharged to the ALF was the choice of the resident and her family. A late entry nurse practitioner (NP) progress note dated May 28, 2024 included that the resident had an advanced COPD, CRF with hypoxia, was O2 (oxygen) dependent at 2 LPM (liters per minute), and used a CPAP (continuous positive airway pressure) at night. The follow-up email from the DoM on June 4 and 5, 2024 addressed to the SSD revealed another request for the physician to sign the documents necessary to discharge the resident to the ALF. The follow-up psych evaluation note dated June 10, 2024 included that the resident was alert and oriented to person, place and time. An email correspondence from the insurance case manager addressed to the SSD (staff #50) and dated June 20, 2024 revealed a request to have TB test completed timely as the resident was very anxious to be discharged . The social service note dated June 21, 2024 included that the SSD followed up with the ALF regarding the resident's transfer to ALF on June 26, 2024. An email correspondence from the DoM to the SSD dated June 21, 2024 revealed that the resident was scheduled for discharge on June 25, 2024. The email from the DoM addressed to the SSD dated June 24, 2024 revealed a request from the resident's family for confirmation that transportation had been set up for June 25, 2024. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The SSD replied to this email on June 25, 2025 (the day of the planned discharge) that it was the role of the accepting facility to set up transportation and not the discharging facility. An email from the DoM addressed to the SSD and dated June 25, 2024 included that per the resident's LTC (long term care) insurance that it should be the discharging facility that sets up transportation. The SSD replied to this email on June 25, 2024 that the resident had a manual wheelchair, had several boxes of personal belongings, and needed home oxygen equipment. However, there was no evidence found in the clinical record that the SSD sent the DME referral for the home oxygen equipment and supplies to the approved DME vendor. Another email from the DoM addressed to the SSD and the LTC case manager and dated June 25, 2025 revealed that the DoM was inquiring whether the home oxygen and DME had been set up for discharge for resident #49. A communication note dated June 25, 2024 included that the concerns with transfer of the resident to the ALF was discussed with the ALF. The order administration note dated June 25, 2024 included that the portable oxygen tank was switched to an oxygen concentrator at bedtime. An email correspondence from the ED (Executive Director of the ALF the resident was going to be transferred) addressed to the facility and dated June 25, 2024 revealed the ED informed the SSD and the DON that it was the role of the discharging facility to set up the DME orders through an approved DME provider for the discharging resident. It also included a request that the facility send the orders including any DME orders, and a discharge summary to assist in the setting-up of the DME referral for Resident #49 for discharge. The ED of the facility (staff #140) replied to this email on June 25, 2025 that the facility does not set up DME orders and will not be arranging transport. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated the resident had moderate cognitive impairment. A late entry mood note dated June 26, 2024 revealed that the resident was in the process of transferring to another facility per the resident and family request. Despite the documentation that the resident will be transferred to the ALF on June 26, 2024, there was no evidence found in the clinical record that discharge plan was developed to assess and address the resident's discharge needs to include oxygen and DME (durable medical equipment) needs. A fax cover sheet with transmission date of June 27, 2024 addressed to the DME provider from the social services revealed a hand written note that the resident was transferring to the ALF; and, to drop off equipment at the ALF and to confirm the delivery date and time. It also included a Respiratory and Durable Medical Equipment Referral form with a blank RX date and included that an oxygen test was done on June 26, 2024. However, this form was signed by the physician on February 6, 2024. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care management note dated June 28, 2024 included that the SSD informed that the DME and transportation for resident #49 were not confirmed. The communication note dated June 30, 2024 included that the resident family was requesting for an update on the resident's DME; and that, the SSD informed the family that a referral was sent and follow-up emails had been provided. Despite the documentation that the DME were not confirmed, there was no evidence found in the clinical record that the DME referral was re-sent to the DME provider; or, that facility asked the DME provider for any clarification as to why the DME referral was not processed or confirmed until July 8, 2024. A fax cover sheet with transmission date of July 8, 2024 addressed to the DME provider from the facility social services included a hand written note that the request was resident #49; and to follow up with the ALF staff. It also included a Respiratory and Durable Medical Equipment Referral form with a blank RX date and included that an oxygen test was done on July 8, 2024. However, this form was signed by the physician but did not have a date as to when it was signed. In an email from the LTC case manager addressed to the SSD, DON, the ED of the ALF and the DoM dated July 08, 2024 included that an oxygen test had be completed and results had to be faxed to the approved DME provider; and, if DME provider receives the DME order and the requested oxygen test, it can be delivered on the same date. It also included that the LTC case manager requested that once the receiving facility confirmed the delivery of the DME, the SSD would schedule transportation for the following date of July 09, 2024. An email correspondence from the DoM addressed to the SSD and dated July 11, 2024 included that the DoM was asking the facility to check the status of the DME equipment referral. Per the documentation, once the DME equipment was delivered, Resident #49 can move in to the ALF. However, the documentation included that the DME equipment had not been delivered to the ALF. In an email from the ED of the ALF addressed to the facility and dated July 12, 2024, the ED of the ALF informed that after reserving the apartment reserved for resident #49 for over a month, the ALF had to released it from being held for Resident #49. Additionally, The ED of the ALF expressed concerns and was feeling uncomfortable with Resident #49 not having a coordinated, safe discharge plan as protected in her resident rights to transition to their community. A communication note dated July 15, 2024 revealed that the SSD informed the resident that the ALF was not holding apartment that was reserved for her when she transfers; and that, things were not completed on time regarding the oxygen. Per the documentation, the SSD that she can continue to find placement that the resident wanted. In an interview conducted with resident #49 on July, 16, 2024 at 2:47 p.m., the resident stated that she was still awaiting discharge from the facility. During the interview, the resident became tearful when she described her strong desire to discharge from the facility; and, verbalized her frustration with how the discharge process was taking an extend time to complete. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the SSD (Staff #50) was conducted on July 17, 2024 at 11:01 a.m. The SSD stated that delayed discharge for resident #49 was due to multiple factors and failing to realize the current barrier to discharge was that the DME provider would not accept the oxygen test on the form that she had faxed twice. During the interview, a review of the clinical record was conducted with the SSD who stated that there was no evidence of any emails or documented phone calls made by the SSD or any staff of the facility to the DME provider for clarification on how to correctly submit an oxygen test for DME orders. During an interview with the DON conducted on July 17, 2024 at 3:09 p.m., the DON stated that the IDT team was involved with discharges and the facility had discharge meeting every week to discuss nursing, case management and the goals for discharge. Regarding the discharge of resident #49, the DON stated that she was not involved with the discharge process for resident #49 until issues came up related to the DME. She stated that she was aware that the family wanted to go to an ALF. Review of the facility's policy titled, Transfers and Discharges (revised June 2024) revealed, for resident-initiated discharges, the medical record should contain documentation or evidence of documented discussions with the resident or, if appropriate, his/her representative.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure one oxygen-dependent resident (#49) did not have an empty oxygen tank while in use. The deficient practice could result in scaling down of services, provided by the facility, that do not align with the highest practicability of care. Findings include: Resident #49 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute and chronic respiratory failure (CRF) with hypoxia, dependence of supplemental oxygen, and heart failure. The care-plan initiated on January 11, 2024 revealed that the resident had oxygen therapy related to COPD. Interventions included O2 (oxygen) via nasal cannula continuous per medical doctor orders. A physician order dated July 18, 2024 revealed an order for oxygen at 2 liters per minute continuously via nasal cannula; may titrate to 4 liters to maintain 88% saturation. An observation conducted on July 18, 2024 at 2:03 p.m. revealed Resident #49 was in the activity room playing bingo with nasal cannula on. The oxygen tank gauge displayed an empty oxygen tank. An interview was conducted on July 18, 2024 with Certified Nursing Assistant (CNA/Staff # 42) who stated that in order to prevent the oxygen tank for Resident #49 from being empty was to monitor the gauge when it was nearing empty. However, the CNA stated that there were instances in the past where the oxygen tank had been empty and it happens. In another observation conducted on July 18, 2024 at 2:03 p.m., the CNA (staff #42) told the resident that she needed a replacement for her oxygen tank. An interview was conducted on July 18, 2024 with Director of Nursing (DON/Staff # 12) who stated that a resident with continuous oxygen orders and utilizing an empty oxygen would not meet the facility's expectations. The DON further stated that if there was an oxygen order for a resident, staff were expected to be checking the resident's oxygen throughout the shift. Review of the facility's policy titled, Administration of Medications (reviewed August 2023) revealed, the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. It also included that staff must adhere to right of medication administration including: Right Time and Frequency, check the order for when it would be given and when was the last time it was given; Right Assessment, note the resident's history and any parameters around drug administration; Right Evaluation, ensure the medication is working the way it should, ensure medications are reviewed regularly, ongoing observations if required.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on personnel file review, staff interviews, facility policy review and Center for Medicare and Medicaid Services (CMS) guideline, the facility failed to ensure that the occupational therapist (OT/staff #88) had a valid Cardiopulmonary Resuscitation (CPR) and first aid certifications. The deficient practice could result in staff not being knowledgeable of how to prvide emergency care to residents. Findings include: Review of the personnel file for an occupational therapist (OT/staff #88) revealed a hire date of [DATE]. Continued review of the personnel file included that the CPR or First Aid certification had an expiration date of February 28, 2012. During an interview conducted on [DATE] at 11:00 a.m, a review of the personnel file of the OT was conducted with the Payroll Coordinator (staff #55) who stated that there was no evidence found of any valid CPR or First Aid certifications for the OT (staff #88). The payroll coordinator stated that she thought that CPR or First Aid certifications were only required for only nurses and nurse aids, and, not required for Physical Therapy (PT)/OT staff. An interview was conducted on [DATE] at 1:42 p.m. with the Director of Nursing (DON, Staff #12) who stated she was told by the Director of Rehabilitaion that CPR and First Aid were longer required of PT or OT staff. Review of Centers for Medicare & Medicaid Services (CMS) guideline on Cardiopulmonary Resuscitation (CPR) in Nursing Homes dated [DATE] included that staff must maintain current CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessment. The facility policy titled, Specialized Rehabilitative Services, included that care provided by facility associates should be coordinated and consistent with the specialized rehabilitative services provided by qualified personnel. The facility policy titled, Competent Staff, included that the facility will have staff with the appropriate competencies and skills needed to provide nursing and related services to assure resident safety and maintain the highest level of care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51158 Based on clinical record review, staff interviews, and policy reviews, the facility failed to ensure there was adequate monitoring for side effects related to the use of a psychotropic medication for one resident (#60). The census was 89. The deficient practice could result in residents being at risk for unidentified adverse reactions related to the use of the medication. Findings include: Resident #60 was admitted on [DATE] with diagnoses of dementia, Alzheimer's disease, cerebral infarction, mild neurocognitive disorder, and altered mental status. The active physician order summary included an order to monitor for side effects related to anti-anxiety medications. The care plan revealed dated December 28, 2023 included that the resident used anti-anxiety medication related to anxiety disorder as evidenced by restlessness. The care plan was revised on January 18, 2024 to include interventions to observe for the occurrence of target behavior, to report as needed any adverse reactions to the medication every shift and to administer the medications as ordered. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], included a Brief Interview for Mental Status with a score of 00 indicating the resident had severe cognitive impairment. A physician order dated June 12, 2024 included for Ativan (antianxiety) 1 mg tablet administered via G-Tube every 8 hours as needed (PRN) for Anxiety as evidenced be (AEB) restlessness for 14 days, starting on June 12, 2024. The follow-up psych evaluation note dated June 17, 2024 included the resident continued to have intermittent episodes of yelling out along with severe restlessness and agitation. Per the documentation, Ativan helped with the symptoms; and that, the resident continued to receive Ativan at least once daily. Plan was to continue Ativan as needed for anxiety as evidenced by restlessness. A follow-up psych evaluation note dated June 24, 2024 revealed that the resident continued to have intermittent episodes of restlessness and agitation along with episodes of yelling out. The documentation included that staff reported the resident responded well to Ativan when he exhibited these behaviors; and that, the record showed that the resident received Ativan at least twice daily for his symptoms of restlessness. The plan was to change Ativan to a scheduled medication twice daily. The orders for Ativan, monitoring for side effects related to its use were transcribed onto the MAR (medication administration review) for June 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for June 2024 revealed that Ativan was administered to the resident on 10 occasions between June 13 and June 24, 2024. However, the MAR revealed that the monitoring for side effects were not documented as completed from June 13 to 24, 2024. The clinical record revealed no evidence that the monitoring for side effects related to the use of Ativan was discontinued or put on hold. An interview was conducted on July 17, 2024 at 10:04 a.m. with a Licensed Practical Nurse (LPN/staff #112), who stated that the resident should be monitored for behaviors and side effects while taking Ativan, regardless of the medication being scheduled or given as needed. The LPN stated that behaviors and side effects monitoring should be documented in the MAR; and, whenever a psychoactive medication such as Ativan was ordered there should be an additional order to monitor for behaviors and side effects related to its use. During the interview, the LPN reviewed the clinical record and stated that there was an active order for Ativan which was administered to the resident. However, the LPN stated that there was no documentation of that the side effects related to the use of Ativan was monitored on June 13 through June 24, 2024. The LPN further stated that the risk could result in staff not being able to monitor the actual effects of the medication on the resident. An interview was conducted on July 17, 2024 at 1:17 p.m. with the Director of Nursing (DON/staff# 12) who stated that residents should be monitored for behaviors and side effects while taking psychoactive medication such as Ativan. During the interview, the DON reviewed the clinical record and stated that there was an active order for Ativan for resident #60 and the medication was administered to the resident on 10 occasions between Jun 13 and 24, 2024. The DON also stated that there was no documentation of side effects monitoring completed during that time period; and that, this could result in staff not identifying the side effects should it happen and could affect the overall care of the resident. Review of the facility policy titled, Psychotropic Medication Use, revealed that psychotropic drugs include but are not limited to antipsychotics, anti-anxiety, and sedative-hypnotics that affect brain activities associated with mental processes and behavior. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medial or psychiatric causes of behavioral symptoms. All medications used to treat behaviors should be monitored for: efficacy, risks, benefits, and harm or adverse consequences.