STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055039	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Rehab and Care Center	1630 N. Edison Street Stockton, CA 95204

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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 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** 40583 Based on interview, and record review, the facility failed to ensure the Physician's Orders for Life Sustaining Treatment (POLST- a written physician's order that documents the types of medical treatment the resident wants to receive during serious illness, for example, chest compressions if the heart stops beating and/or a tube placed down the throat if breathing stops) was fully completed and/or uploaded to the resident's Electronic Health Record ([EHR]- information stored in the facility's computer system) per facility policy for 1 of 21 sampled residents (Resident 64). This failure had the potential for a delay in treatment for Resident 64 during a medical emergency and/or the incorrect life sustaining treatment administered to Resident 64. Findings: A review of Resident 64's medical record titled, Admission Record, indicated Resident 64 was admitted to the facility with diagnoses which included diabetes (problems with blood sugar) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). A review of Resident 64's clinical record titled, Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], indicated the sections requiring resident information were not completed. Section A, Cardiopulmonary Resuscitation (CPR), had the box checked for Do Not Attempt Resuscitation/DNR, (meaning no life saving measures were to be taken). Section D, Information and Signatures, did not contain Resident 64's name and the area for Resident 64's signature was blank. During a concurrent interview and record review with licensed nurse (LN) 8, on [DATE], at 9:12 AM, LN 8 explained the first section of the POLST lets staff know what to do in the event the resident was not breathing, or there was no pulse. LN 8 further explained the last section contained information on discussion with the resident and whoever the resident discussed it with. LN 8 confirmed there was no identifying information on the POLST for Resident 64. LN 8 stated if staff were to look in the chart to see what to do in the event Resident 64 required life saving measures, and there was no identifying information for Resident 64, they would have to do a full code (provide CPR). LN 8 stated, If it is not filled out, I would not consider this to be his document, and while it indicates DNR I would have to start compressions [the part of CPR in which the rescuer pushes on the chest]. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Nursing (DON), on [DATE], at 9:20 AM, the DON stated it was important to have resident identifying information on the POLST in case the document was misfiled. The DON explained staff would not know who the POLST belonged to because there was no identifying information listed. The DON stated, If there was no name, we would not know if the paper was his and we would have to do a full code. A review of the facility policy titled, POLST (Physician's Order for Life Sustaining Treatment, reviewed [DATE], indicated, .The POLST form is to be completed based on the patient's expressed treatment preferences and medical conditions .In order to be valid, the POLST must be signed by a physician, and by the patient, or if the patient lacks decisionmaking capacity the legally recognized health care decisionmaker .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43943 Based on observation, interview, and record review, the facility failed to ensure 2 of 21 sampled residents (Resident 75 and Resident 81) received care and services safely when Resident 75 and Resident 81 were unable to open bathroom door #7. This failure led to feelings of entrapment (caught, trapped or entangled) and the inability to maintain independence with Activities of Daily Living (ADL - examples: toileting, shaving, brushing teeth). Findings: a. During a review of Resident 75's clinical record titled Admission Record, (a document that contains the resident's demographic information), the record indicated Resident 75's diagnosis included muscle weakness. During an interview with Resident 75 on 3/5/24, at 10 a.m., Resident 75 stated she had not been able to open hallway bathroom door #7 by herself because the door was too heavy. A review of Resident 75's clinical record titled Minimum Data Set Section GG Functional Abilities and Goals, (MDS - an assessment tool utilized for facilitating care management in the nursing home), indicated Resident 75 did not have any impairment (weakness) on her upper shoulders, elbows, wrists, and hands. Resident 75 utilized a manual wheelchair and a walker. A review of Resident 75's clinical record titled Care Plan, dated 6/8/23, indicated toileting required limited assistance. During an observation on 3/5/24, at 4:30 p.m., the Department attempted to open bathroom door #7. The bathroom door was difficult to open (heavy door and sticky door jamb), and the doorknob needed to be yanked a few times before it would open. When the door shut, it was observed the door latch did not completely engage, leaving the door slightly ajar (open). During a concurrent observation and interview with Resident 75 on 3/5/24, at 4:37 p.m., Resident 75 was observed attempting to exit bathroom [ROOM NUMBER]. Resident 75 used her foot to nudge open the door (multiple times) to get the door to open wide enough to get her wheelchair through the bathroom door. Resident 75 stated it took her a while to open the door because the door was heavy. During an interview with Licensed Nurse (LN) 9 on 3/5/24, at 4:40 p.m., LN 9 stated depending on the weather, bathroom door #7 could be sticky and hard to open. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 1 on 3/5/24, at 4:42 p. m., CNA 1 was observed attempting to close bathroom door #7. CNA 1 verified that bathroom door #7 would not completely shut and was open at the top of the door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LN 9 on 3/5/24, at 5:05 p.m., LN 9 stated bathroom door #7 appeared to be a fire door (fire doors are heavy to be able to contain a fire) and needed to be replaced. During a concurrent observation and interview with the Maintenance Director (MD) on 3/6/24, at 3:16 p.m., bathroom door #7 was observed. MD verified the bathroom door knob was loose and the door was difficult to open and close. MD stated the bathroom door was very heavy and possibly a fire door; however, the expectation was that the residents were all able to open the bathroom door independently, if that was their ability. During an interview with the Director of Nursing (DON) on 3/6/24, at 3:22 p.m., the DON stated her expectation was that the residents could open the bathroom doors independently to maintain their level of independence and dignity. b. During a review of Resident 81's clinical record titled Admission Record, (a document that contains the resident's demographic information) indicated Resident 81's diagnoses included muscle weakness and loss of right leg. During an interview with Resident 81 on 3/4/24, at 2:12 PM, stated the door to bathroom [ROOM NUMBER] was too heavy for him to open. Resident 81 stated he informed the staff about this problem on the morning on 3/4/24. Resident 81 stated he went into the bathroom because he wanted to shave. Resident 81 stated he had a hard time opening the door and once he was in the bathroom, he needed to use the call light in the bathroom to have someone open the door. Resident 81 stated he had concerns he would be trapped in the bathroom if there was a fire. A review of Resident 81's clinical record titled Care Plan, dated 2/5/24, indicated Resident 81 was able to use his upper extremities to wash his upper body. During a concurrent observation and joint interview with Resident 81 and LN 9 on 3/5/24, at 5:05 p.m., Resident 81 was observed struggling to get his wheelchair up the slight incline on the floor leading up to bathroom door #7. Resident 81 was using the hallway handrails to hoist himself up the ramp in his wheelchair to reach the bathroom door knob. Resident 81 attempted to grab the door knob 3 times, sliding down the floor incline each time. Resident 81 eventually was able to grab the bathroom door knob and then had difficulty getting the door to open as it was stuck closed. It took Resident 81 approximately two minutes to get the bathroom door open. Resident 81 was observed entering bathroom [ROOM NUMBER] and then pressed the bathroom call light for assistance to exit the bathroom. Once out of the bathroom, Resident 81 stated he was unable to open the bathroom door independently due to the heaviness of the door. LN 9 stated the door was way too heavy for him [Resident 81] to open. LN 9 further stated Resident 81 would be at risk for falls associated with struggling to open bathroom door #7 while in a wheelchair. LN 9 stated the door appeared to be a fire door and needed to be replaced. During an interview with Resident 81 on 3/5/24, at 5:10 p.m., Resident 81 stated he felt claustrophobic (fear of closed spaces) and stuck in the bathroom when he was unable to open bathroom door #7. Resident 81 stated he had entered the bathroom to shave but the big slope outside the bathroom door made it very difficult to enter the bathroom in his wheelchair. Resident 81 explained the bathroom door was solid, very heavy, and not manageable. Resident 81 stated the event of not being able to open the bathroom door was traumatic. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 3/6/24, at 3:22 p.m., with the DON and Resident 81, the DON asked Resident 81 to open bathroom door #7. Resident 81 stated he would not go in the bathroom again because he was unable to get back out of the bathroom independently because the door was too heavy. Resident 81 stated earlier in the week when he was inside bathroom [ROOM NUMBER] and could not open the door, he felt claustrophobic and was afraid he would not be able to get out of the bathroom if there was a fire. The DON stated her expectation was that the residents could open the bathroom doors independently to maintain their level of independence and dignity. During a concurrent interview and record review with the DON on 3/6/24, at 3:25 p.m., the undated document titled, Policy and Procedures on Resident Accommodation of Needs, was reviewed. The document indicated, It shall be this facility's policy to uphold resident's right to reside and receive services in the facility with reasonable accommodations of resident's needs .8. Other areas where facility should reasonably accommodate a resident's individual needs and preferences shall include but not limit to .b). Environment c). Quality of Life . The DON acknowledged the P&P was not followed when the residents did not have easy access to bathroom [ROOM NUMBER].

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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. 40903 Based on interview, and record review, the facility failed to develop and implement psychotropic (mind altering medications often used to treat mood disorder, anxiety, or depression) and high-risk medication (medication known to cause serious harmful effect due to nature of the product) care plans (a component of care that outlines nursing care to provide coordinated and resident specific care to improve overall health and ensure appropriate nursing actions) for 3 out of 21 sampled residents (Resident 80, Resident 57, and Resident 28) when: 1. Resident 80's psychotropic medication use was not care planned for the licensed staff to monitor the progress and use of the two medications called duloxetine (also known as Cymbalta mind altering medication used to treat depression) and cariprazine (also known as Vraylar, a mind-altering drug used to treat mood disorder), 2. Resident 80's blood thinner medication (by thinning the blood , the medicine could cause bleeding and at the same time prevented blood clot formation, heart attack or stroke) use was not care planned for the licensed staff to monitor progress and adverse effects of combination of three medications called apixaban (also known as Eliquis, drug used to prevent blood clot by thinning the blood), ticagrelor (also known as Brilinta, drug used to thin the blood to prevent stroke or heart attack) and naproxen (also known as Naprosyn, a pain medication known to have bleeding side effects) that could have resulted in bleeding side effects, 3. Resident 57's blood thinner medication use was not care planned for the licensed staff to monitor the adverse effect of two medications called clopidogrel (also known as Plavix, drug used to thin the blood to prevent stroke or heart attack) and aspirin (a drug often used for prevention of heart attack by thinning the blood); and, 4. Resident 28's antidepressant medication use was not care planned for the licensed staff to plan the progress and the use of duloxetine (also known as Cymbalta, a medication used to treat depression) medication. These failures could contribute to unsafe medication use, without appropriate monitoring and interventions when indicated. Findings: 1. During a concurrent interview and record review with Licensed Nurse (LN) 1 and the Director of Nursing (DON), on 3/5/24, at 5:06 PM, in the DON's office, the electronic and paper version of Resident 80's medical record was reviewed. Review of the records did not show any documented care plan to monitor the use of mind-altering medications ordered for Resident 80. The record indicated duloxetine and cariprazine were ordered on 2/28/24 and the resident was not monitored for use, adverse effects and the goal or anticipated outcomes. The DON and LN 1 both acknowledged the findings. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review with LN 1 and the DON on 3/5/24, at 5:06 PM, in the DON's office, the electronic and paper version of Resident 80's medical record was reviewed. The review of the record did not show any documented care plan to monitor the use of high-risk medications to address nursing care in preventing, addressing, updating and monitoring the potential for bleeding and other adverse effects with the concurrent use of apixaban, ticagrelor and naproxen. The DON and LN 1 both acknowledged the findings. 3. During a record review of Resident 57's paper based medical record titled Order Summary Report, dated 2/27/24, the record under the Pharmacy (medication orders) section indicated Resident 57 had orders for aspirin and Plavix since 9/7/23 for stroke prevention. The record under other orders did not show any monitoring as directed by the nursing plan of care. During a review of Resident 57's paper based medical record on 3/5/24, at 9 AM, the record under the section Care Plan, did not indicate a plan of care for use of blood thinner medications aspirin and Plavix to guide nursing staff to manage the safe use and monitoring of these two medications. During an interview with the DON and LN 1 on 3/5/24, at 5:15 PM, in the DON's office, the DON stated the care plan should have reflected the nursing care and how the problem list and related medications were addressed. The DON acknowledged the findings. 4. During a record review of the Resident 28's electronic medical record titled Order Summary Report, dated 3/6/24, the record under the Pharmacy section indicated a doctor's order for duloxetine for treatment of depression since 12/14/23. During a concurrent interview and record review with LN 2 on 3/6/24, at 3:37 PM, Resident 28's paper based medical record at nursing station 2 was reviewed, the record under the section Care Plan, did not indicate a plan of care for depression, use of duloxetine, and how the nursing staff should have been monitoring the resident's progress to a set goal of safety and improvements. LN 2 confirmed the finding. Review of an undated facility policy titled, Policy and Procedure on Care Plan, the policy indicated, the facility shall ensure development of a comprehensive care plan for each resident to meet his/her medical, nursing, and mental and psychosocial needs as identified . The policy further indicated, Care Plans should be oriented to prevention of avoidable declines .Care Plans must show evidence of facility's effort to address or manage risk factors . Review of an undated facility policy titled Policy and Procedure on Chemical Restraints, the policy on section 3 indicated, The psychotropic Drug Assessment shall be completed and include .Behavioral problem or behavioral manifestation .in order for resident to achieve his/her highest level of .mental well-being. The policy on section 7 indicated, Formulate plan of care indicating the duration and circumstances under which the chemical restraint is to be used. Approaches to prevent decreased in functioning including monitoring of possible adverse reaction shall also be included.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 40903 Based on observation, interview, and record review, the facility failed to ensure safe practices in handling hazardous medications (Drugs that pose short- or long-term harm upon exposure to human via skin or inhalation) during storage and medication administration with a resident census of 79. The unsafe handling of hazardous medications could pose a health risk to staff and residents. Findings: 1. During a medication administration observation with Licensed Nurse (LN) 5, on 3/4/24, at 8:44 AM, at Hallway 3, LN 5 administered Resident 33's medication, in pill form, called valproic acid (or Depakote, used to treat seizure or used for mental issues) without using any gloves during preparation or administration of the medication. During a review of Resident 33's Medication Administration Record (or MAR, where nursing staff look at doctor's order during medication administration), dated 3/2024, the MAR did not have any instruction on how to handle the medication during pouring and administration related to hazardous drug handling. 2. During a medication administration observation with LN 4, on 3/4/24, at 9:40 AM, at Station 3, LN 4 administered Resident 55's medication, in pill form, called valproic acid without using any gloves during preparation or administration. During a review of Resident 55's Medication Administration Record (or MAR), dated 3/2024, the MAR did not have any instruction on how to handle the medication during pouring and administration related to hazardous drug handling. 3. During a medication administration observation with LN 4, on 3/4/24, at 9:55 AM, at Station 3, LN 4 administered Resident 8's medication, in pill form, called finasteride (or Proscar, medication used to treat prostate issues) without using any gloves during preparation or administration. A review of the Resident 8's MAR, dated 3/2024, the MAR did not have any instruction on how to handle the medication during pouring and administration. 4. During a medication administration observation with LN 5, on 3/5/24, at 9:45 AM, in Hallway 2, LN 5 administered Resident 10's medication, in liquid form, called valproic acid by pouring into a small cup without having any gloves or other personal protective measures during preparation and administration via the tube feeding (or TF when a tube surgically inserted into the stomach for food and drug administration). The valproic acid bottle in the medication cart was not contained in a zip lock bag to prevent accidental touch contamination. A review of the Resident 10's MAR, dated 3/2024, the MAR did not have any instruction on how to handle the medication during pouring and administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LN 4, on 3/6/24, at 2:59 PM, at Station 3, LN 4 stated she was not aware of special handling or use of glove with drugs that were hazardous. The label from pharmacy only stated, not to take if pregnant. During an interview with LN 5, on 3/7/24, at 10:45 AM, at Station 1, LN 5 stated she was not aware of hazardous medication handling and use of gloves or protective measures. LN 5 stated having a specific warning or guidance on the MAR or drug label would have helped during direct resident care. During an interview with the Director of Nursing (DON), on 3/7/24, at 9:28 AM, at Station 1, the DON stated the facility was revising their policy to help nursing staff safely handle hazardous drugs. The DON stated she was aware of the shortcomings. Review of the drug information for Valproic acid, last accessed via Lexicomp (a drug information database) on 3/14/24, the information indicated to handle the medication as a hazardous drug as follows, Hazardous Drugs Handling Considerations; Hazardous agent (NIOSH .National Institute for Occupational Safety and Health (NIOSH) conducts research and makes recommendations for the prevention of work-related injury and illness) .Use appropriate precautions for receiving, handling, administration, and disposal .Gloves (single) should be worn during receiving, unpacking, and placing in storage. NIOSH recommends single gloving for administration of intact tablets or capsules. NIOSH recommends double gloving, a protective gown, and (if there is a potential for vomit or spit up) eye/face protection for administration of an oral liquid/feeding tube administration. Review of the drug information for finasteride (Proscar), last accessed via Lexicomp, on 3/14/24, the drug information indicated the following: Hazardous Drugs Handling Considerations: Hazardous agent (NIOSH .). Use appropriate precautions for receiving handling, administration, and disposal. Gloves (single) should be worn during receiving, unpacking, and placing in storage. NIOSH recommends single gloving for administration of intact tablets or capsules . Review of the Center for Disease Control's National Institute for Occupational Safety and Health (CDC, and NIOSH, a federal agency sets standard of safety in health care) document, titled Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated 4/2023, the document indicated, Many .drugs intended for individual use can be hazardous to healthcare workers with potential occupational exposure to those who handle, prepare, dispense, administer, or dispose of these drugs. Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes .PPE (or Personal Protective Equipment, items like glove or mask) provides worker protection to reduce exposure to hazardous drugs .Efforts should be made to reduce all worker exposures to hazardous drugs. Occupational exposure to hazardous drugs merits serious consideration, as workers may be exposed daily to multiple hazardous drugs over many years. NIOSH suggests careful precautions and safeguards to protect workers, fetuses, and breastfed infants. Further review of the document indicated to use single glove for handling intact tablet form and double glove for handling oral liquid form of the hazardous medications as directed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43943 Based on observation, interview, and record review, the facility failed to ensure a safe environment, and adequate supervision for one of four sampled residents (Resident 72) when: 1. Resident 72's fall risk assessment was not completed accurately and fall interventions were not updated after Resident 72 experienced multiple falls in February of 2024; and, 2. Resident 72 eloped (leaving) from the facility on 1/29/24, without staff being aware until they were contacted by the police department. These failures may have contributed to Resident 72's recurrent falls and the potential for serious injury, negatively effecting Resident 72's health and well-being. Findings: 1. During a review of Resident 72's clinical record titled, Admission Record, (a document that contains the resident's demographic information) indicated Resident 72's diagnosis included epilepsy (a brain disorder that leads to involuntary movements), Merrf syndrome (a syndrome that results in brief, sudden, jerking muscle movements, impaired ability to coordinate movements), and muscle weakness. During an observation on 3/4/24, at 3:35 p.m., Resident 72 was observed sitting in her bed with her knees up to chest. Resident 72 was observed experiencing moderate (average amount in intensity), intermittent (stopping for a time) tremors (involuntary movements) affecting her arms and legs. A review of Resident 72's clinical record titled, Fall Risk Assessment (a standardized assessment that predicts the resident's risk of a fall so interventions can be implemented), dated 1/29/24, indicated section G -Medications (antiseizure [medicines to combat a brain disorder that leads to involuntary movements], Benzodiazepines [medications to reduce anxiety], sedatives [medications used for calming measures], psychotropics [psychiatric medications], narcotics [prescription pain medications], antihypertensive [blood pressure management medications]) was left blank. A total score of 10 or more indicated a high fall risk. Resident 72 scored a 7 on the fall assessment. Section G choices were: 0= none of these medications taken currently or within last 7 days 2= Takes 1-2 of these medications currently and/or within last 7 days 4 = Takes 3-4 of these medications currently and/or within last 7 days 1 = If resident has had a change in medication and/or change in dosage in the past 5 days = score 1 additional point (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Nursing (DON), on 3/6/24, at 10:57 a.m., Resident 72's Fall Risk Assessment, dated 1/29/24, was reviewed. The DON stated the Fall Risk Assessment score was incorrect, and the score should have been an 11 (due to current medications), which would have alertd staff Resident 72 was at high risk for falls and additional interventions should have been in place. During an interview with Licensed Nurse (LN) 1, on 3/6/24, at 9:15 a.m., LN 5 stated Resident 72 was at risk for falls because of her diagnosis of tremors and seizures. A review of Resident 72's clinical record titled, Nurses Notes, dated 2/5/24, at 5:30 p.m., indicated Certified Nursing Assistant (CNA) found Resident 72 on the floor. Resident 72's roommate reported Resident 72 had tried to get up out of bed. A review of Resident 72's clinical record titled, Nurses Notes, dated 2/11/24 at 10:15 p.m., indicated Resident 72's roommate yelled for a CNA to come to the room. The CNA reported seeing Resident 72 on the floor with a cut on her forehead and blood coming from her head. According to the roommate, Resident 72 had tried to get out of bed. A review of Resident 72'c clinical record titled, Nurses Notes, dated 2/16/24, at 9:50 p.m., indicated Resident 72 had an unwitnessed fall and the housekeeper found Resident 72 sitting on the floor in the hallway of the facility. During an interview with LN 5 on 3/6/24, at 9:38 a.m., LN 5 stated Resident 72 was a high fall risk because of her diagnosis of seizures. LN 5 stated Resident 72 was unstable and needed assistance with getting out of bed and with her personal hygiene needs. LN 5 stated Resident 72 had fallen while at the facility. LN 5 stated the staff could have gotten a physician's order for a fall mat (a padded mat that cushions a fall) to be placed next to Resident 72's bed. LN 5 verified Resident 72 did not currently have a fall mat in place. During a review of the Resident 72's clinical record titled, Client Protection Plan For Safety: Seizure, dated 1/26/24, indicated Resident 72 was at risk for falls related to seizure disorder. The interventions included an applied body alarm (a portable alarm on the resident's person that alarms when transferring from one level to another) to alert nursing staff of an unsafe transfer. During an interview with the DON on 3/6/24, at 11 a.m., the DON stated a body alarm was attempted, however, Resident 72 took the alarm off. The DON stated the failed intervention was not updated on the care plan and new interventions were not implemented after the falls. During a concurrent interview and record review with the DON on 3/6/24, at 11:13 a.m., the undated document titled, Policy and Procedure on Protocol for Prevention, Monitoring and Recording of Accidents and Incidents, was reviewed. The document indicated, . Facility shall implement measures to prevent . accidents and incidents .6. Immediate corrective actions should be taken to prevent accidents or incidents . 12. Examples of resident-related accidents or incidents include .falls .14. Documentation of resident accident or incident shall contain the following information .immediate intervention to prevent recurrence of accident or incident . The DON acknowledged the policy and procedure was not followed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 72's medical record titled, Nurses Notes, dated 1/29/24, indicated, .Police Department called facility to state resident found at a nail salon on [nail salon address] .2 staff members to resident sitting on chair in nail salon stable. Asked resident to come back to the facility, resident stated, 'No I'm not going back. I don't want to go back with you.' Explained to resident risk for safety. Resident still refused. 2 police officer interviewed resident and staff. Resident stands and pushes wheelchair with steady gait out of nail salon to side-walk. Asked resident where she is going. Resident states she is going to El Dorado street. Police officer asked resident why she wants to go. Resident states she does not want to go back. [family member (FM) 2] was called. Met resident at sidewalk, talked to resident and assisted resident back to facility. In stable condition . A review of Resident 72's medical record titled, Elopement Risk Evaluation, dated 1/29/24, indicated a score of 15, indicating Resident 72 was at Moderate Risk, for elopement, and required care planning to address safety risks. A review of Resident 72's care plans did not indicate a care plan was initiated for Elopement Risk. During an interview with FM 1 and FM 2, on 3/6/24, at 11:58 AM, FM 1 stated the nail salon had called the police and when the officer arrived, he found Resident 72's information on the wheelchair and called the facility. FM 1 further stated the facility found out where Resident 72 was when the police called the facility. During an interview with Police Officer (PO) 1, on 3/6/24, at 3:20 PM, PO 1 stated they got a call for a lady at a nail salon. PO 1 stated the call was dispatched at 11:36 AM, PO 1 got on scene at 11:45 AM and contacted the facility at 11:52 AM letting the facility know where the resident was. PO 1 explained FM 2 helped staff escort Resident 72 back to the facility. During an interview with Licensed Nurse (LN) 1, on 3/6/24, at 3:59 PM, LN 1 stated the first time the facility became aware Resident 72 was missing was when the police called the facility. LN 1 further stated the facility did not know how long Resident 72 was missing prior to the police calling. LN 1 stated staff contacted Resident 72's emergency contact so they could bring Resident 72 back to the facility safely as Resident 72 did not want to go back to the facility. During an interview with the Director of Nurses (DON), on 3/6/24, at 4:16 PM, the DON stated the process for an elopement is to first call the family, then call the physician, and then would report it to the police. A review of an undated facility policy and procedure (P&P) titled, Elopement Policy and Procedure, the P&P indicated, .Upon admission, when a resident is assessed to be Elopement Risk, an evaluation will be done . resident has been found to be elopement risk .stay in the facility an evaluation of the resident will also be done to ensure that staff monitors the resident's whereabouts .

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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. 43943 Based on observation, interview, and record review, the facility failed to follow the Physician's orders for one of 34 residents receiving supplemental (additional) oxygen (Resident 80). This failure resulted in Resident 80 receiving over twice the ordered amount of supplemental oxygen and could have led to injury due to a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - long term inflammatory lung disease that causes obstructed airflow from the lungs and too much oxygen could cause a person to lose their drive to breathe). Findings: During a review of Resident 80's clinical record titled, Admission Record (a document that contains the resident's demographic information), the record indicated Resident 80's diagnosis included COPD and asthma (chronic lung disease that can cause coughing, wheezing, and shortness of breath). A review of Resident 80's clinical record titled, Physician Orders, dated 1/17/2024, indicated Resident 80 had a physician's order for supplemental oxygen at 2 Liters (L) via nasal canula (device that delivers extra oxygen through a tube and into the nose). During an observation on 3/4/2024 at 10:57 a.m., observed Resident 80 on 5 L of supplemental oxygen via nasal canula. During an observation on 3/6/2024 at 8:00 a.m., observed Resident 80 to be on 3.5 L of supplemental oxygen via nasal canula. During an interview with Licensed Nurse (LN) 6, on 3/4/2024 at 11:27 a.m., LN 6 stated Resident 80's current physician's order for oxygen was 2 L via nasal cannula. LN 6 stated Resident 80 was currently on 5 L of supplemental oxygen and the facility was not following the physician's orders. LN 6 stated she would contact the physician to get the order changed from 2 L of supplemental oxygen to 5 L of supplemental oxygen via nasal canula. A review of Resident 80's clinical record titled, O2 [oxygen] Sats [saturations] Summary (amount of oxygen in the blood), dated 1/2024 through 2/2024, indicated Resident 80 was not placed on the ordered supplemental oxygen on the following dates: 1/18/2024 - 3 L supplemental oxygen via nasal cannula 1/19/2024 - 3 L supplemental oxygen via nasal cannula 1/23/2024 - 3 L supplemental oxygen via nasal cannula 1/24/2024 - 3 L supplemental oxygen via nasal cannula 1/25/2024 - 3 L supplemental oxygen via nasal cannula (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/28/2024 - 3 L supplemental oxygen via nasal cannula 1/30/2024 - 3 L supplemental oxygen via nasal cannula 2/3/2024 - 3 L supplemental oxygen via nasal cannula 2/4/2024 - 3 L supplemental oxygen via nasal cannula 2/25/2024 - 3 L supplemental oxygen via nasal cannula A review of Resident 80's clinical record titled, Care Plan, dated 1/24/2024, indicated Resident 80 was at risk for injury related to respiratory problems such as shortness of breath, cough, and wheezing. One of the interventions included to administer oxygen as ordered by the physician. During an interview with LN 4, on 3/6/2024 at 8:45 a.m., LN 4 stated supplemental oxygen should be administered per physician's order. LN 4 stated if Resident 80 had a hard time breathing and needed additional oxygen support, she would have called the physician for a new oxygen order before changing the oxygen flow rate. During a concurrent interview and record review on 3/6/2024 at 8:08 a.m., with the Director of Nursing (DON), the Policy and Procedure (P&P) titled, [FACILITY NAME] Policies and Procedures on Oxygen Therapy, not dated, was reviewed. The Policy and Procedure indicated, Policy. It is this facility policy to provide oxygen to residents, in a safe and therapeutic manner. Oxygen therapy shall be administered as ordered by the physician . 9. Licenses nurse shall also check and ensure that correct oxygen flow rate is administered in accordance with physician order . 18. Oxygen saturation level shall be monitored as needed and ordered by the physician . The DON acknowledged the P&P was not followed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 43943 Based on interview and record review, the facility failed to ensure one of 21 sampled resident's (Resident 28) pain was managed, when the facility did not notify the physician of Resident 28's severe pain, and treated Resident 28 with a medication ordered to manage mild to moderate pain. This failure resulted in Resident 28 experiencing unmanaged pain for long periods of time. Findings: During a review of Resident 28's clinical record titled, Admission Record (a document that contains the resident's demographic information), the record indicated Resident 28's diagnoses included paralysis (inability to move the body) affecting the left side of the body following a stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts - causing parts of the brain to die). During an interview with Resident 28 on 3/6/24 at 1:38 p.m., Resident 28 stated his left leg was in pain. Resident 28 stated his left leg was crushed during the Vietnam War. Resident 28 stated it made him feel like a little kid when the facility would not give him the correct medication to keep his pain under control. A review of Resident 28's clinical record titled, Physician Progress Notes, by Phys.1 indicated: 6/14/23- Resident 28 complained of left knee pain; 7/14/23 - Resident 28 complained of left knee pain; 8/15/23 - Resident 28 complained of left knee pain; 9/2/2023 Resident 28 complained of left knee pain; 1/6/2024 - Resident 28 complained of left knee pain; 2/3/2024 - Resident 28 complained of left knee pain. A review of Resident 28's clinical record titled, Order Summary Report, dated 6/4/2023, indicated Resident 28 had an order for ibuprofen (over the counter pain reducer) Oral Tablet 600 milligrams (mg - unit of measurement) every 8 hours as needed for mild to moderate pain (Pain Scale Utilized - Faces Pain Rating Scale with a scale of 0-10, where 0-4 = mild pain, 5-7 = moderate pain, and 8-10= severe pain). A further review of Resident 28's clinical record titled, Order Summary Report, dated, 11/16/2023, indicated Resident 28 had an order for Morphine Sulfate Extended Release (prescription narcotic medication used to treat severe pain) Oral Tablet - 15 mg every 24 hours as needed for severe pain (8 through 10 on the Faces Pain Rating Scale) and was ordered to be administered at bedtime. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 28's clinical record titled, Initial/Annual/Status Change Pain Assessment, dated 2/12/24, by Phys.1, indicated Resident 28's acceptable pain level (level of pain that did not require pain medication intervention) was assessed by utilizing the Faces Pain Rating Scale. Resident 28 reported his acceptable pain level was between 1 - 4 out of 10. A review of Resident 28's clinical record titled, Medication Administration Record (MAR), dated 1/2024 through 3/2024, and Progress Notes, dated 1/2024 through 3/2024, indicated ibuprofen 600 mg (ordered for mild to moderate pain) was administered to Resident 28 for severe pain on: 1/1/2024 - pain level of 8/10 - left leg pain 1/2/2024 - pain level of 8/10 - left leg pain 1/10/2024 - pain level of 9/10 - left leg pain 1/11/2024 - pain level of 9/10 - left leg pain 1/20/2024 - pain level of 9/10 - left leg pain 1/21/2024 - pain level of 9/10 - left knee pain 1/26/2024 - pain level of 9/10 - left leg pain 2/1/2024 - pain level of 9/10 - left leg pain 2/2/2024 - pain level of 9/10 - left knee pain 2/3/2024 - pain level of 9/10 - left knee pain 2/8/2024 - pain level of 9/10 -left knee pain 2/9/2024 - pain level of 9/10 - left knee pain 2/10/2024 - pain level of 9/10 - left knee pain 2/13/2024 - pain level of 9/10 - left knee pain 2/19/2024 - pain level of 9/10 - left leg pain 2/20/2024 - pain level of 9/10 - left knee pain 2/22/2024 - pain level of 8/10 - left knee pain 2/26/2024 - pain level of 9/10 - left leg pain 2/27/2024 - pain level of 9/10 - left knee pain 3/2/2023 - pain level of 9/10 - left leg pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/3/2024 - pain level of 9/10 - left knee pain 3/5/2023 -- pain level of 9/10 - left leg pain A review of Resident 28's clinical record titled, Client Protection Plan: Safety/Fall indicated Resident 28 was at risk for reoccurrence of pain or discomfort related to a diagnosis of stroke and inability to move the left side of the body. Interventions included to offer pain medication, monitor for effectiveness and ineffectiveness, and notify the physician. During a concurrent interview and record review on 3/6/2024, at 1:42 p.m., with the Licensed Nurse (LN) 5, Resident 28's MAR, dated 1/2024 through 3/2024 was reviewed. LN 5 stated according to the MAR, Resident 28 was ordered to receive ibuprofen for mild to moderate pain and Morphine for severe pain at bedtime. LN 5 stated the licensed nurse should have called the physician for a new medication order to address the severe pain during the daytime hours. LN 5 verified the facility did not manage Resident 28's severe pain during the daytime hours. During a phone interview with Phys. 1 on 3/6/2024 at 2:19 p.m., Phys. 1 stated Resident 28 could have benefited from around the clock pain medication and the licensed nurses should have communicated to the primary physician the severity of Resident 28's pain during the daytime hours. During a concurrent interview and record review, on 3/6/2024 at 2:05 p.m., with the Director of Nursing (DON), the document titled, Policy and Procedures on Physician Notification, not dated, was reviewed. The Policy and Procedure (P&P) indicated, It is the policy of this facility to notify the attending physician of any significant change in a resident's condition . The Licensed nurse shall promptly notify primary physician of any significant change in resident's conditions. Examples of significant changes . others as deemed appropriate . The DON stated the licensed nurses should have called the physician for an additional pain medication order to cover severe pain during the day. The DON acknowledged the P & P was not followed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 40583 Based on observation, interview, and record review, the facility failed to apply appropriate siderails for 1 of 21 sampled residents (Resident 63), when Resident 63 was ordered half siderails but was found with two full bed siderails in use. This failure had the potential to cause restricted exiting from the bed, increased risk of injury, increased depression, and entrapment. Findings: A review of Resident 63's medical document titled, Admission Record, indicated Resident 63 was admitted to the facility with diagnoses which included post-traumatic stress disorder (PTSD - a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), and depression. During an observation in Resident 63's room, on 3/5/24, at 9:51 AM, Resident 63 was lying in bed with her eyes open. Resident 63's bed was equipped with full siderails bilaterally (on both sides of the bed) which were up at the time of the observation. Resident 63 was non-interviewable. During an observation in Resident 63's room, on 3/6/24, at 3:15 PM, Resident 63 was lying in bed with her full siderails up bilaterally. A review of Resident 63's medical record titled, Fall Risk Assessment, dated 4/24/23, indicated a score of 14, with scores above 10 indicating a high risk for falls. A review of Resident 63's medical record titled, Siderail Assessment, dated 4/22/23, indicated, .Res. [resident] is ambulatory (including use of assistive devices .Yes .How is resident condition .Impaired Judgement .What is the reason for potential use of siderails .As enabler to promote safe bed transfers .If siderails will be used, describe how often it will be used .bed mobility .What kind of siderails will be used .half rail, both sides . A review of Resident 63's medical record titled, Order Summary Report [contains physician order], with active orders as of 3/6/24, indicated, .TX [treatment]: Half siderails up as enabler for bed mobility & transfers . order date 5/28/22 . During a concurrent observation, interview, and record review, with licensed nurse (LN) 8, on 3/6/24, at 3:16 PM, LN 8 confirmed Resident 63's bed had full siderails. LN 8 explained Resident 63 had an order for 1/2 bedrails, not the full siderails. LN 8 further explained full siderails were more of a danger to residents as they could get caught up in them and they could fall if they tried to climb over them. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review, with the Director of Nurses (DON), on 3/6/24, at 3:41 PM, the DON confirmed Resident 63's bed was equipped with full siderails. The DON reviewed Resident 63's bedrail order and confirmed the order indicated 1/2 bedrails. The DON further reviewed Resident 63's siderail assessment, siderail care plan, and siderail consent. The DON stated there was not an assessment, care plan, or consent in place for full siderails, only the 1/2 bedrails. The DON explained the siderails were to accommodate residents needs and if Resident 63 was using the siderails for mobility they need to be appropriate. The DON further explained the importance of appropriate use of siderails was to ensure all disciplines were aware of the type of siderail the residents are supplied with, and to plan the residents care. The DON stated siderails were considered a restraint. A review of an undated facility policy and procedure (P&P) titled, Siderail Assessment, the P&P indicated, .It shall be this facility's policy to assess a resident for the appropriate use of bed rails or siderails and provide necessary care and services that will reduce or limit adverse effect of use of siderails .licensed nurse shall complete the Siderail Assessment when determining appropriateness of use of siderails to address medical symptom or condition of resident .resident's medical symptom requires use of siderails, resident shall be referred to members of the interdisciplinary team for further assessment and identification of use of least restrictive measures .Plan of care shall be developed to address use of siderails including preventing or reducing associated risks of use of siderails .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40903 Based on observation, interview, and record review the facility failed to ensure prescribed medication unavailability was communicated to the medical doctor and failed to ensure vital medications were available for administration for two residents (Resident 43 and Resident 80), in a sample of 21, when: 1. Anxiety and narcotic pain medications were not available for administration for Resident 43 with Post Traumatic Stress Disorder (PTSD); 2. Insulin (medication in shot form to treat high blood sugar level) was not available for Resident 80 with a diabetic (blood sugar disease) diagnosis. These failures had the potential to negatively impact Resident 43 and Resident 80's health and well-being. The facility also failed to ensure safe pharmaceutical services with medication disposal, waste, and the accountability of delivered medications based on standards of practice for a resident census of 79 when: 3. Pharmaceutical waste (discontinued or no longer needed drugs) including prescription and narcotic (drugs with potential for abuse) medications were not rendered unusable when disposed in the pharmaceutical waste bin (also known as a drug waste bucket) and were accessible with hand retrieval from the waste bin. 4. Prescription drug disposition records were not co-signed and witnessed by a licensed staff during destruction and disposal; and, 5. Medication delivery receipts and manifests by the pharmacy provider were not signed by licensed staff for accountability and accuracy. These failures could result in unsafe disposal of the discontinued prescription medications and the risk of drug diversion (illegal use of drugs). Findings: 1a. A review of Resident 43's Admission Record, indicated Resident 43 was admitted to the facility with diagnoses which included PTSD and Parkinson's Disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination, and musculoskeletal pain is experienced by up to 75 percent of people, and includes pain in the muscles, bones or skeleton). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 43, on 3/4/24, at 11:46 AM, Resident 43 stated she was okay until she ran out of medication. Resident 43 explained sometimes she had to go three to four days without her anxiety medication. Resident 43 further explained since residing in the facility, noises and enclosed places caused her anxiety. A review of Resident 43's medical record titled, Medication Administration Record (MAR), dated 2/1/24 through 2/29/24, indicated, Alprazolam [an anxiety medication and a controlled substance] Oral Tablet 0.25 MG [milligrams - a unit of measure] .Give 2 tablet by mouth one time a day for Anxiety M/B [manifested by] Fidgeting Up & About Give 2 tabs [tablets-total dosage 0.5 mg] po [by mouth] for anxiety at 2200 [10 PM]-Start Date 5/23/23 . was not available for administration on the following days: 2/9/24, 2/25/24, 2/26/24, and 2/27/24. A review of Resident 43's MAR, dated 2/1/24 through 2/29/24, indicated, Alprazolam Oral Tablet 0.25 MG . Give 1 tablet by mouth two times a day for Anxiety M/B Fidgeting Up & About Give 1 tab [0.25 mg] po for anxiety at 0600 [6 AM] & 1400 [2 PM]. -Start Date-5/23/23 . was not available for administration on the following day: 2/9/24, 2/25/24, 2/26/24, and 2/27/24. During an interview with the Pharmacist (Pharm), on 3/7/24, at 10:15 AM, the Pharm explained the process for facilities to request a refill of a controlled substance was the facility sends the request for controlled substances to the physician's office for approval. The Pharm further explained, once the physician approves it, they would fill it. The Pharm stated sometimes the Physician (Phys. 3) did not respond right away. The Pharm further stated they had been having problems with Phys. 3 signing the requests for controlled substances. During an interview with Phys. 3, on 3/7/24, at 10:38 AM, Phys. 3 explained the process was the pharmacy faxed the request to Phys. 3, Phys. 3 reviewed it and faxed it back to the pharmacy. Phys. 3 further explained the pharmacy then filled the prescription and sent it to the facility. Phys. 3 stated, regarding the Alprazolam, I don't really know why it wasn't available. When I fax it to the pharmacy, I assumed they got it. If they got it, they should have filled it. Regarding whether an alternative to Alprazolam should have been made available for Resident 43 when the Alprazolam was not available for administration, Phys. 3 stated he agreed, an alternative should have been supplied. During a concurrent interview and record review with the DON, on 3/7/24, at 11:38 AM, the DON confirmed Resident 72 was not administered her scheduled Alprazolam on 2/9/24, 2/25/24, 2/26/24, and 2/27/24. The DON explained the Alprazolam had been requested on 2/24/24 and confirmed there was no documented evidence that there had been another request and there were no progress notes indicating the facility had contacted the pharmacy to follow-up. The DON further confirmed there was no documented evidence the Medical Director had been contacted either. The DON stated the facility should have contacted the Medical Director. During a follow-up interview with Phys. 3, on 3/7/24, at 11:57 AM, Phys. 3 stated in the future he would make sure and complete the requests for controlled substances right away. 1b. A review of Resident 43's MAR, dated 3/1/24 through 3/31/24, indicated, Tramadol HCl (controlled pain medication) Tablet 50 MG give 0.5 tablet by mouth two times a day for Moderate to Severe Pain . was not available for administration on the following days: 3/3/24, 3/4/24, and 3/5/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Phys. 3, on 3/7/24, at 10:38 AM, Phys. 3 stated he did not remember being notified of an issue with Resident 43's Tramadol (controlled pain medication). During an interview with the DON, on 3/7/24, at 11:10 AM, the DON explained the process for re-ordering controlled substances like Alprazolam and Tramadol was when there was a physician's order for a controlled substance, to fax the pharmacy, and the pharmacy sent a C2 form (form for controlled substances) to the physician, the physician signed it and faxed it back to the pharmacy, the pharmacy filled the prescription and sent it to the facility. The DON stated the nurses would contact the pharmacy frequently to follow up so there was not a delay in filling the prescription. The DON explained if it had been over 24 hours the facility was supposed to call the medical director to ensure the C2 form was filled out and sent. During a concurrent interview and record review with the DON, on 3/7/24, at 11:38 AM, the DON confirmed the Tramadol was not available for administration between 3/3/24 and 3/5/24. The DON confirmed there were requests to the pharmacy for the Tramadol on 3/3/24 and 3/5/24. The DON stated the e-kit (contains medications) contained Tramadol, and the nurses would have to contact the physician to get approval to access it and administer the medication. A review of the facility policy and procedure (P&P) titled, Policy and Procedure on Physician Orders, undated, the P&P indicated, .It shall be this facility's policy to provide care and services to the resident in accordance with physician orders .All aspects of care, including but not limited to the following shall only be provided if ordered by the physician .Medications . A review of the pharmacy policy, supplied by the facility, titled, Medication Ordering and Receiving From Pharmacy: .Receiving Controlled Substances, effective date 8/1/2019, indicated, .controlled substances and medications classified as controlled substances .are subject to special ordering, receipt, and recordkeeping by the facility .Controlled substances are reordered when a [five day] supply remains to allow for transmittal of the required written prescription to the pharmacists . 2. During a review of Resident 80's medical record titled Medication Administration Record (or MAR, where medication and nursing administration records are kept), dated 3/2024, the record indicated an order for insulin glargine (a long-acting insulin) subcutaneous (shot under the skin) to be given twice a day since 1/17/24. Further review of the MAR indicated no insulin Glargine was documented as given on the morning of 3/1/24 and 3/2/24 and was marked with code number 9 in the record. The code number 9 was explained as Other/See Progress Notes. Review of Resident 80's electronic medical record, titled Administration Note, dated 3/1/24, at 10:27 AM, the note indicated Insulin Glargine Subcutaneous .Medication not given. Awaiting pharmacy supply. MD [Medical Doctor] aware. Pt [patient] in stable condition. Review of Resident 80's electronic medical record, titled Administration Note, dated 3/2/24, at 9:29 AM, the note indicated Insulin Glargine Subcutaneous .Medication not given due. Awaiting pharmacy delivery. MD aware. Pt in stable condition. Further review of Resident 80's MAR, dated 3/2024, indicated the afternoon doses of insulin glargine were administered at 9 PM on 3/1/24 and 3/2/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 80's blood sugar levels measured on 3/1/24 at 5:26 PM, indicated the level was high at 406 mg/dL (normal blood sugar level is 80-120; mg/dL is milligram per deciliter, a measure of unit) despite being on other insulin and diabetic products. The electronic nursing administration notes did not indicate if the medical doctor was contacted. In an interview with DON, on 3/5/24, at 5:06 PM, the DON stated the nursing staff could have called the doctor to use the emergency supply of the insulin in the emergency kit (supply of medication in the facility for emergency use when pharmacy supply not available) so the resident could have received the ordered medication. DON was not sure if medical doctor addressed high blood sugar after resident missed the morning insulin. Review of the facility's policy, titled Medication Administration-General Guidelines, dated 1/2018, the policy on documentation indicated If a dose of regularly scheduled medication is withheld .not available .an explanatory note is entered on the .record. If . a vital medication is withheld, or not available the physician is notified. Nursing documents the notification and physician response. Review of the undated facility's policy, titled Medical Director Job Description, the policy indicated Assist the facility in incorporating current standards of practice into resident care policies and procedures to help assure that they address the needs of the residents. The policy further indicated Assisting the facility in assuring the other practitioners who may perform physician delegated tasks, act within the regulatory requirements and within their scope of practice defined by the state law. 3. During a concurrent observation of the facility's medication room at Station 2, and interview with Licensed Nurse (LN) 7, on 3/4/24, at 10:53 AM, the medication disposition bin (Pharmaceutical waste bin) was accessible by hand and the pills and products were not rendered unusable. Additionally, the container had a clear plastic bag lining (similar to a garbage bag) with a very strong foul smell upon opening the lid. The medication disposal bin contained multiple unopened bottles of medications and inhalation products in addition to individual pills reachable by hand. LN 7 confirmed the finding and stated he was not sure why it smelled, and pills inside the waste bin were retrievable by hand. 4. During a concurrent interview and record review with the Director of Nursing (DON), on 3/5/24, at 9:57 AM, the destruction record for prescription medication was reviewed. The destruction record included medications that were discontinued, or the residents were no longer there to use them. The record listed the name and quantity of the medication disposed along with a signature space for a co-signer (a person that witnessed the medication destruction). The records further indicated there was no co-signature by a licensed staff for non-controlled medications. The DON stated discontinued medications including narcotic (controlled opioid medications subject to abuse) medications were disposed in the pharmaceutical waste bin located in the medication room. The DON stated the pharmaceutical bins were last collected on 1/25/24 by the waste disposal contractor. The DON stated she was not aware that the staff had placed full bottles of prescription medication in the bin and the loose pills were reachable by hand. The DON was not sure what the clear garbage bag lining in the bin was used for and no one reported the foul smell to her. The DON acknowledged the witness signature pages were missing from the non-narcotic disposition documentation consistently. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a concurrent observation and interview with LN 7, in Station 2, on 3/4/24, at 11 AM, the record for medication receipts and delivery was reviewed. The white binder had sheets of delivery records from the provider pharmacy. The paper sheets listed the name and quantity of medications delivered. The medications included controlled medications and non-controlled medications. The delivery receipt was not consistently signed by a licensed staff including the narcotic medications delivery sheet. LN 7 acknowledged the findings and stated they received delivery from provider pharmacy two times per day. LN 7 was not sure why a large number of delivery sheets were not signed. In an interview with the DON, in her office, on 3/5/24, at 10:56 AM, the DON stated the delivered medication should have been checked for accountability and accuracy by the licensed staff receiving it. The DON stated the staff had been signing the delivery driver's record for the pharmacy, but the facility's record should have been signed. Review of the facility's policy titled, Ordering and Receiving from Pharmacy, dated 8/1/19, indicated, Medication and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. Review of the facility's policy titled, Preparation and General Guidelines: Controlled Substances, dated 8/1/19, indicated, Medications included in the Drug Enforcement Administration [DEA- a federal agency that monitors use of controlled opioid medications] classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. The policy further indicated, Medications supplies by the provider pharmacy shall identify medications as controlled drugs, either as a part of the label (i.e., a red letter C stamped on the label) . Review of the facility's policy titled, Disposal of Medications ., dated 8/1/19, section E indicated, Medication destruction occurs only in the presence of at least two licensed healthcare professional or according to regulation and applicable law. Review of the facility's policy titled, Controlled Substance Disposal, dated 8/1/19, indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. The policy did not address a disposal method in the facility to render the drug unusable and prevent risk of drug diversion.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 40903 Based on interview and record review, the facility failed to monitor the adverse effects of high-risk medications (medication known to cause serious harmful effect due to nature of the product) in two out of five residents (Resident 80 and Resident 57) sampled for unnecessary drugs when: 1. Resident 80's blood thinner medications (by thinning the blood , the medicine could cause bleeding and at the same time prevent blood clot formation, heart attack or stroke) was not monitored for adverse effects of apixaban (also known as Eliquis, drug used to prevent blood clot by thinning the blood), ticagrelor (also known as Brilinta, drug used to thin the blood to prevent stroke or heart attack) and naproxen (also known as Naprosyn, a pain medication known to have bleeding side effects) with a known adverse bleeding side effects per manufacturer drug information; and, 2. Resident 57's blood thinner medication was not monitored for adverse effect of clopidogrel (also known as Plavix, drug used to thin the blood to prevent stroke or heart attack) and aspirin (a drug often used for prevention of heart attack by thinning the blood) with a possible adverse bleeding side effect per manufacturer drug information. These failures could contribute to unsafe medication use and adverse side effects such as bleeding in the body. Findings: 1. During a review of Resident 80's medical record titled, Order Summary Report, dated 3/2024, the record indicated the following blood thinner and pain medications orders: Eliquis Oral Tablet 5 MG (apixaban; MG is milligram, a measure of unit); Give 1 tablet by mouth every 12 hours for atrial fibrillation (a heart Rhythm disease); Start Date: 1/18/24. Ticagrelor Oral Tablet 90 MG (ticagrelor); Give 1 tablet by mouth two times a day for CVA PROPHYLAXIS (Stroke prevention); Start Date: 1/17/24. Naproxen Oral Tablet 500 MG (Naprosyn; a pain medication with bleeding side effect): Give 1 tablet by mouth two times a day for PAIN; Start Date: 2/3/24. Further review of the report did not show if nursing staff were monitoring the adverse effects of these medications. During a concurrent interview and record review on 3/5/24, at 5:06 PM, with Licensed Nurse (LN) 1 and the Director of Nursing (DON), in the DON office, the electronic and paper version of Resident 80's medical record was reviewed. Review of the records did not show any documented monitoring of the high-risk medication use by nursing staff. The DON acknowledged the finding. DON stated this was overlooked and the combination of three medications increased the potential for risk of bleeding. 2. During a review of Resident 57's paper based medical record titled, Order Summary Report, dated 2/27/24, the record indicated the following blood thinner medication orders: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aspirin 81 Oral Tablet Chewable; Give 1 tablet by mouth one time a day for CVA, STROKE PROPHYLAXIS [stroke prevention]; Start Date: 9/7/23. Clopidogrel Bisulfate Oral Tablet 75 MG [Plavix]; Give 1 tablet by mouth one time a day for CVA, STROKE PROPHYLAXIS; Start Date: 9/7/23. Further review of the report did not show if nursing staff were monitoring the adverse effects of these two medications as of 3/4/24. During concurrent interview with the DON and LN 1, in the DON's office, on 3/5/24, at 5:15 PM, the DON stated the nursing monitoring should have been part of daily care and resident assessment. The DON acknowledged the shortcomings. Review of the facility's undated policy titled, Medication Monitoring and Management: Preventing, and Detecting Adverse Consequences indicated, The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis in accordance with the policy . The policy in section B indicated, When a resident received a new medication, the medication order is evaluated for the . dose . duration, and monitoring are in agreement with current clinical practice . and/or manufacturer specification for use. The policy in section C indicated, facility staff monitor the resident for possible medication-related adverse consequences . The policy in Section E indicated, the facility staff monitor residents on the following combinations for possible adverse consequences . The policy further included a table listing of high-risk medications that did not include the newer blood thinner medications used in the facility.

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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. 40903 Based on interview and record review, the facility failed to develop and implement psychotropic (mind altering medications often used to treat mood disorder, anxiety, or depression) medication side effect and behavior monitoring in one out of five sampled residents (Resident 80) when Resident 80's duloxetine (also known as Cymbalta mind altering medication used to treat depression) and cariprazine (also known as Vraylar, a mind-altering drug used to treat mood disorder) were not monitored based on manufacturer instructions and standards of practice. This failure could have contributed to unsafe medication use and contribute to lack of progress in Resident 80's mental health care. Findings: During a review of Resident 80's medical record titled, Order Summary Report dated 3/2024, the record indicated the following mind-altering medication orders: Cariprazine HCl Oral Capsule 1.5 MG [or Vraylar, MG is milligram a unit of measure]; Give 1 capsule by mouth one time a day related to ANXIETY .Start Date: 2/27/24. DULoxetine HCl Oral Capsule . 60 MG [or Cymbalta]; Give 1 capsule by mouth one time a day related to ANXIETY .Start Date: 2/27/24. Further review of the report did not show if nursing staff were monitoring the adverse effects and targeted behaviors related to Resident 80's anxiety with the use of these medications. During a concurrent interview and record review on 3/5/24, at 5:06 PM, with Licensed Nurse (LN) 1 and the Director of Nursing (DON), in the DON office, the electronic and paper version of Resident 80's medical record was reviewed. Review of the records did not show any documented daily monitoring by nursing staff for the use of mind-altering medications ordered for Resident 80. LN 1 confirmed duloxetine and cariprazine were ordered on 2/28/24, and the resident was not monitored for use of these two medications for adverse effects and a targeted behavior with the goal of monitoring improvement or worsening of the mental health issues. The DON acknowledged the findings and stated this was overlooked when the other discontinued mind-altering drug was still active in the medical record for monitoring. Review of the facility's undated policy titled, Policy and Procedure on Chemical Restraints, the policy indicated, The facility shall use psychotherapeutic drug or chemical restraint on residents as part of a plan to eliminate or modify symptoms for which the drug is prescribed . health record must contain a diagnosis and specific behavior manifestation for which the medication is being used . The policy in section 3 indicated, The psychotropic Drug Assessment shall be completed and include . Behavioral problem or behavioral manifestation for which use of psychotherapeutic drug . in order for resident to achieve his/her highest level of . mental well-being . IDT recommendation on how drug therapy will be evaluated, including monitoring of resident for possible adverse drug reactions .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903 Based on observation, interview, and record review the facility failed to ensure safe medication storage and labeling practices were based on standards of practice with census of 79 when: 1. The Emergency Kit (or Ekit- a supply of products for use when urgently needed) for IV (Intravenous, into the vein) medications was not labeled with a list of items or the earliest beyond use date (or expiration date) in medication room at Station 3. 2. Expired hand gel (a liquid gel for hand sanitization) bottles were stored in the active storage area in the medication room at Station 3. 3. Undated and opened medication container was stored in the unlocked refrigerator at Station 3's medication room where staff's personal bags were stored at the same time. 4. Undated, unsecured, and opened medication containers were stored in the medication room at Station 1 including the unlocked refrigerator where food items were stored along side medications. 5. Unlabeled and undated medications were stored in the active storage areas in medication cart 2, medication cart 3 and and treatment cart 2. These failures could contribute to unsafe medication use and storage in the facility. Findings: 1. During a concurrent interview and inspection of the facility's medications room at Station 3, on [DATE], at 10:39 AM, accompanied by Licensed Nurse (LN) 3, the Ekit for IV medication was located on the floor, sealed with a red tag with no label or list indicating the contents or the earliest expiration date of items stored inside. LN 3 acknowledged the finding and stated she would call the pharmacy to get a new Ekit with proper labeling. 2. During a concurrent interview and inspection of the facility's medications room at Station 3, on [DATE], at 10:39 AM, accompanied by LN 3, the small and large bottles of sanitizing hand gel were outdated as follows: i. Hand Sanitizer 500 mL (mL stands for milliliter, a measure of volume) was marked as expired on [DATE]. ii. Germ-X Moisturizing Hand Sanitizer; one gallon (gallon is a measure of volume) was marked as expired on ,d+[DATE]. LN 3 acknowledged the finding and stated she would remove the outdated hand gel products from other areas of the facility. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent interview and inspection of the facility's medication room at Station 3, on [DATE], at 10:39 AM, accompanied by LN 3, the medication refrigerator was not locked and stored the Ekit for refrigerated medications including lorazepam (or Ativan, a controlled medication used to treat anxiety). Further inspection of the refrigerator indicated a multi-dose open vial of a testing product called Tuberculin Purified Protein Derivative (Mantoux) (PPD-a product injected into skin to test for tuberculosis, a dangerous lung infection) not marked with the open date when it was used for the first time. The staff's personal bags and lunch boxes were sitting on a container in the medication room. LN 3 acknowledged the findings and stated the refrigerator had no lock and the PPD vial should have been marked when first used. LN 3 stated the staff had their own lockers and should not have stored the personal belongings in the medication room. 4. During a concurrent interview and inspection of the facility's medication room at Station 1, on [DATE], at 10:53 AM, accompanied by LN 7, the unlocked medication refrigerator was marked with a label For Medications Only. The refrigerator contained ice cream and nutritional supplements along with refrigerated medications on the same shelves. Further inspection of the refrigerator indicated a multi-dose opened vial of PPD testing product with no open date marked on the vial. Further observation indicated the Ekit for controlled medications (drugs with potential for abuse) was sealed and stored on an unlocked shelf in the medication room. LN 7 acknowledged the findings. 5a. During a concurrent interview and inspection of the facility's medication cart at Station 2, on [DATE], at 3 PM, accompanied by LN 5, the cart contained the following: i. One box of ipratropium and albuterol (or Duoneb- a breathing treatment for shortness of breath) in an opened foiled pouch with no open date marked on the container. The label on the foil pouch indicated Once removed from the foil pouch, the individual vial should be used within two weeks. ii. One container of inhaler called Umeclidinium and vilanterol inhalation (or Anoro Ellipta, a combination inhalation product to treat respiratory disease) with open date marked [DATE]. The label on the product container indicated Discard the inhaler 6 weeks after opening the moisture-protective foil tray. LN 5 acknowledged the findings and removed the products from active storage. 5b. During a concurrent interview and inspection of the facility's medication cart at Station 2, on [DATE], at 3:15 PM, accompanied by LN 4, the cart stored the following: i. Two boxes of ipratropium and albuterol (or Duoneb- a breathing treatment for shortness of breath) in an opened foiled pouch with no open date marked on the containers. The label on the foil pouch indicated, Once removed from the foil pouch, the individual vial should be used within two weeks. ii. An opened eye drop called latanoprost (or Xalatan, eye drop to treat glaucoma, an eye disease) not marked with the date it was opened and removed from the refrigerator. The yellow pharmacy label on the box indicated Refrigerate the unopened product. May store at room temperature after opening. Once bottle is opened, discard unused medication after 6 weeks. iii. An open container of inhalation aerosol called budesonide and Formoterol (or Symbicort, a combination inhalation medicine used to treat lung disease) with no open date marked on the box. The label on the box indicated Discard within three months after removing from the foil pouch. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LN 4 acknowledged the findings and removed the products from active storage. 5c. During a concurrent interview and inspection of the facility's treatment cart at Station 2, on [DATE], at 9:37 AM, accompanied by Nurse Consultant (RN-Consultant), the cart stored: i. A prescription topical cream called Silver Sulfadiazine or SSD (a cream used to treat or prevent infection related to skin burn) 50 gm (gm, or gram, a unit of weight) that did not have a resident label on the container. ii. An opened half used bottle of Sterile . Normal Saline USP 100mL (germ free salt solution; mL is milliliter and unit of volume) with a marking Do not reuse on the label. RN-Consultant acknowledged the finding and removed the product form the storage. In an interview with Director of Nursing (DON), in her office, on [DATE], at 10:49 AM, the DON stated the staff should follow the policy on multi-dose container for dating and beyond use date. The DON stated each medication had a different instruction on when to discard. The DON stated she was aware of unlocked refrigerator, and it should have been used only for medications. The DON stated the list of medications should have been posted outside of the Ekit. A review of the facility's policy, titled Storage of Medications, dated [DATE], indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendation or those of the suppliers. The policy further indicated, Certain medications or package types .,multiple dose injectable vials, ophthalmic (eye medicine) . once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. A review of the facility's policy titled, Controlled Substance Storage, dated [DATE], the policy indicated, Medications included in .classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. The policy further indicated, Scheduled . medications and other medications subject to abuse or diversion are stored in a permanently affixed double locked compartment separate from all other medications .

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 40583 Based on interview and record review, the facility failed to ensure a review of the Facility Assessment (document containing information on the resident population, facility resources, and a community-based risk assessment), was conducted at least annually. This failure had the potential to negatively affect the health and well-being of all residents residing in the facility. Findings: A review of the Facility Assessment, provided by the facility, indicated the last time the Facility Assessment was reviewed and updated, was January 17, 2018. During a concurrent interview and record review with the Administrator (ADM) and Director of Nurses, (DON), on 3/7/24, at 11:05 AM, the ADM confirmed the last time the facility assessment had been updated was 1/17/18. The ADM explained the Facility Assessment should have been updated and reviewed at least annually. A review of the facility policy titled, Facility Assessment, undated, indicated, .It is the policy of this facility that it must conduct and document an individualized facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies . The facility will review and update the facility assessment annually and as necessary .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40903 Based on observation, interview, and record review the facility failed to ensure safe infection prevention practices with a census of 79 according to standards of practice when: 1. The facility failed to ensure safe infection control practices with use of shared Blood Pressure (BP) devices (a device that measures rate of blood flow using the arm or the wrist) in-between resident care with Resident 55, Resident 69, and Resident 80. 2. The facility failed to ensure safe infection prevention practices with the use of a shared glucometer (device used to measure blood sugar) in-between resident care with Resident 3, Resident 15, Resident 17, and Resident 36. 3. The facility failed to ensure a water management program (a program to reduce the risk of growth and spread of bacteria in a water system which can cause serious lung infections) was developed and implemented in the facility. 4. The facility failed to ensure Resident 19's room was clean, and free from sources of infection. These failures could contribute to unsanitary medical device use and the spread of infection in the facility. Findings: 1a. During a medication administration observation, with Licensed Nurse (LN) 4, at Station 3, on 3/4/24, at 9:40 AM, LN 4 used an electronic blood pressure device to measure Resident 55's blood pressure by attaching the device to the wrist. LN 4 then exited the room and placed the device on top of the medication cart without cleaning or sanitizing it. 1b. During a medication administration observation, with LN 4, at Station 3, on 3/4/24, at 9:50 AM, LN 4 used the same electronic blood pressure device (that was not sanitized) to measure Resident 69's blood pressure, by attaching the device to the wrist while Resident 69 was sleeping in the bed. The blood pressure device was not cleaned and sanitized after use. 1c. During a subsequent medication administration observation, with LN 4, at Station 3, on 3/4/24, at 10:12 AM, LN 4 used the same electronic blood pressure device (that was not sanitized) to measure Resident 80's blood pressure by placing it on Resident 80's wrist. In an interview with LN 4, at nursing Station 3, on 3/6/24, at 2:59 PM, LN 4 stated she should have used the bleach wipe to clean and sanitize the BP cuff that touched the resident's skin. In an interview with Infection Preventionist (IP), on 3/7/24, at 9:45 AM, the IP stated she expected the staff to clean and sanitize the shared BP devices with the facility's approved disinfectant wipe before and after each use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON), on 3/7/24, at 12:52 PM, the DON stated BP devices should be sanitized before and after each use. Review of the undated facility's policy, titled Policy and Procedure for use of Digital Blood Pressure Monitor, the policy indicated After use, clean the blood pressure cuff and monitor according to the manufacturer's instruction and facility protocols. 2a. During a medication administration observation, with Licensed Nurse (LN) 7, at Station 1, on 3/4/24, at 11:40 AM, LN 7 gathered the glucometer and supplies needed to measure Resident 15's the blood sugar. LN 7 with gloved hand poked Resident 15's left finger to get blood and then soaked the test strip attached to glucometer with the blood. LN 7 then exited the room and cleaned the glucometer with two pieces of small alcohol wipes. 2b. During a subsequent medication administration observation with LN 7, at Station 1, on 3/4/24, at 11:53 AM, LN 7 used the same glucometer to measure Resident 36's blood sugar. LN 7 took the glucometer and supplies to Resident 36's bedside and poked the left finger to get blood to measure the blood sugar. LN 7 exited the room and used two small alcohol wipes to sanitize the glucometer. 2c. During a medication administration observation, with Licensed Nurse (LN) 4, on 3/4/24, at 12:01 PM, at Station 3, LN 4 gathered glucometer and supplies into Resident 3's room to measure the blood sugar. LN 4 with poked the left finger and squeezed it to get blood for the test. LN 4 then exited the room and cleaned the glucometer with two small alcohol pads very quickly. 2d. During the subsequent medication administration observation, with LN 4, on 4/4/24, at 12:25 PM, at Station 3, LN 4 used the same glucometer that was cleaned with the alcohol pads, to measure the blood sugar of Resident 17. LN 4 took the glucometer and supplies into the room, poked Resident 17's right middle finger to get blood, and then soaked the test strip with blood to measure the blood sugar. LN 4 exited the room and used small alcohol wipes to clean the glucometer. In an interview with LN 7, on 3/6/24, at 2:20 PM, LN 7 stated he was trained for one month when he followed other senior nurses on how to manage medication administration including blood sugar measurement using a glucometer. LN 7 stated he was trained to clean the glucometer with an alcohol wipe before and after each use. In an interview with LN 4, on 3/6/24, at 2:59 PM, LN 4 stated she followed how she was trained to clean the glucometer with alcohol wipes. She was not aware any other method of cleaning and sanitizing the glucometer in-between resident care. In an interview with Infection Preventionist (IP) on 3/7/24, at 10:03 AM, the IP stated the nursing staff should use facility provided wipes to clean the glucometer before and after each use and leave the device on a flat surface to air dry. The IP stated the alcohol pad would not disinfect the serious bugs often seen in a health care setting. The IP stated the nurse had to follow the manufacturer instruction as well. The IP stated she was not aware of a policy that instructed nurses to use alcohol wipes for sanitization of the shared glucometer. The IP acknowledge the current facility approved wipe would not cover all the serious bugs that could spread very quickly via simple touch. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with DON, on 3/5/24, at 10:56 AM, in her office, the DON stated the glucometer use policy was reviewed on 1/24/24 by the Quality Assurance committee. The DON stated she expected the nurses to be trained based on policy and manufacturer recommendation on how to handle or clean the resident care devices including glucometer. The DON stated the facility's Policy needed to be reviewed in order to be in line with most recent guidelines. Review of the facility's undated policy, titled Glucometer Machine Cleaning, the policy indicated Glucometer machine shall be cleaned daily and as when contamination is likely. The procedure section indicated Clean the glucometer machine with 70% (% or percent, measure of potency) alcohol wipes every after-patient use. Review of facility's undated policy, titled Glucometer Machine Cleaning Policy and Procedures, the policy indicated Disinfect with 1:10 bleach solution or OSHA (or Occupational Safety and Health Act ensure safe and healthful working conditions for workers by setting and enforcing standards) approved disinfectant with a facial tissue on the exterior only. This policy was not consistent with previous policy on use of cleaning agents. Review of CDC (Center for Disease Control, nation's leading science-based, data-driven, service organization that protects the public's health) guideline titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration last accessed via https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html#anchor_1556215485 ,on 3/14/24, the guideline indicated If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared. 33424 3. During an interview on 3/7/24 at 11:40 a.m., the Administrator stated the facility did not have a policy and procedure for the required water management program. During an interview on 3/7/24 at 12:00 p.m., the Administrator stated she had worked at the facility for more than [AGE] years and there had never been a water management program at all during that time. During an interview on 3/7/24 at 12:05 p.m., the Infection preventionist stated the facility not having a water management program placed residents at risk for water borne illnesses. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a memo released by the Centers for Medicare and Medicaid Services (CMS) to all healthcare facilities, dated 7/6/18, and titled, Requirement to Reduce Legionella [bacteria that can cause serious lung infections] Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD), the memo indicated, . Legionella can cause a serious type of pneumonia [lung infection] . Those at risk include persons who are at least [AGE] years old, smokers, or those with underlying medical conditions such as chronic lung disease .Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including .long-term care facilities .Transmission [spread] can occur via .devices such as showerheads .Facilities must develop and adhere to policies and procedures that inhibit [prevent] microbial growth [growth of bacteria] in building water systems that reduce the risk of growth and spread of Legionella .and other .pathogens [bacteria] in water .Legionella can grow in parts of building water systems that are continually wet, and certain devices can spread contaminated water droplets . Examples of these .devices include .Hot and cold water storage tanks .Water heaters .Pipes, valves, and fittings .Water filters .faucets . 43943 4. A review of Resident 19's clinical record titled, Admission Record (a document that contains the resident's demographic information), indicated Resident 19's diagnoses included Urinary Tract Infection (UTI - infection of the bladder and/or kidneys), pseudomonas (bacteria [germ] that is found commonly in the environment and was difficult to treat), and sepsis [blood infection] due to Escherichia (bacteria found in the gut (GI) and environment). During a review of Resident 19's clinical record titled, History and Physical [H+P], dated 6/16/23, written by Physician 3, the H+P indicated Resident 19 had chronic (occurring often) UTIs, and chronic indwelling Foley catheter use (tube placed in the bladder to empty urine and requires extreme cleanliness to avoid infection), due to neurogenic bladder (lack of bladder control due to nerve problems). During a concurrent observation and interview on 3/4/2024 at 12:37 p.m., with Resident 19, the condition of Resident 19's room was observed. There was a strong sour smell in the room. There was a portable hanging clothes rack on the left side of the bed with seven hanging jackets and four large plastic totes under the portable hanging clothes rack. The portable hanging clothes rack was between the head of the beds of Resident 19's and his roommate. To the right of Resident 19's bed, there were approximately 10 large plastic bags that were stuffed in the corner of the room (by the head of the bed). The pile of bags was spilling over to the right side on Resident 19's bed. The plastic bag pile went over the height of the windowsill and was approximately four feet tall. Resident 19's bedside table was covered in paper towels, trash, an empty plastic container, and a black trash bag. There was no empty clean surface area on the bedside table. Resident 19's electric wheelchair had 2 pillows on the seat of the chair, a large folded up blanket, and a bedliner on top of the wheelchair. The items on the wheelchair reached the top of the back area of the wheelchair. There were three full urinals (portable receptacle used for holding urine) observed in the trash can in Resident 19's room. Resident 19 stated he purchased items when he went to town and took them back to his room. During a concurrent observation and interview on 3/4/2024 at 12:44 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 19's room smelled sour, and the room posed a hazard due to all the clutter of items in the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LN 5, on 3/4/2024 at 12:57 p.m., LN 5 stated Resident 19 had a foley catheter placed, but it was recently removed. LN 5 stated Resident 21 had a current UTI. LN 5 stated she was unsure what items were in the plastic bags and Resident 19 hoarded items. During a concurrent observation and interview with the Infection Preventionist Nurse (IP) on 3/6/2024 at 2:40 p.m., the IP stated she had concerns with Resident 19's room as it pertained to the clutter and infection control. The IP stated Resident 19's room was a source of infection, and she was unaware of where the items in his room came from, and stated the room had a musty smell. During an interview with the Director of Nursing (DON) on 3/04/2024 at 3:00 p.m.,the DON stated the items in Resident 19's room was an infection control issue, in which the bagged items could attract insects and pests. A review of Resident 19's clinical record titled, Care Plan, dated 7/2/2023, indicated Resident had multiple bags of belongings in his room. The goal was to be able to comply with infection control and fire hazard policies and procedures. The plan included to rid the room of things that were not needed and to remind the resident of fire hazards and infection control concerns. During a concurrent interview and record review on 3/6/2024 at 3:40 p.m., with the Director of Nursing (DON), the Policy and Procure (P&P) titled, Housekeeping Department, not dated, indicated, . The purpose of this policy is to decrease the risk of disease transmission . and to ensure an effective infection control program . and will comply with all local, state, and federal laws, standards, regulations, and guidelines . The DON acknowledged the P&P was not followed.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40583 Based on observation and interview, four rooms (rooms 5, 18, 22, and 45) in the facility did not meet the required 80 square feet per resident. This failure placed the residents in rooms 5, 18, 22, and 45 at potential risk to impede their care and highest possible level of functioning due to smaller than required square footage. Findings: During an observation with the Maintenance Director (MD), the following measurements were obtained for rooms [ROOM NUMBER]. An interview with the Administrator (ADM) confirmed the room size of room [ROOM NUMBER]. a. room [ROOM NUMBER], a 3-bed room, measured 236.73 square feet, rather than the required 240 square feet. b. room [ROOM NUMBER], a 3-bed room, measured 238 square feet, rather than the required 240 square feet; c. room [ROOM NUMBER] a 3-bed room, measured 231.2 square feet, rather than the required 240 square feet; and, d. room [ROOM NUMBER], a 2-bed room, measured 140 square feet, rather than the required 160 square feet. a. During a concurrent observation and interview with Resident 46 (an unsampled resident) in room [ROOM NUMBER], on 3/4/24, at 10:03 AM, Resident 46 stated there was enough space in the room for her and she did not have any concerns. The room had adequate space to keep Resident 46's wheelchair in the room without hindering workable area or access to the residents residing in the room. During an interview with Resident 56 (an unsampled resident), on 3/5/24, at 11:15 AM, Resident 56 stated she did not have any concerns with the space she was provided. Resident 56 further stated she had everything she needed. During an observation on 3/5/24, at 11:28 AM, a staff member was observed in room [ROOM NUMBER]. The staff member was able to work with residents effectively in the space available. During an interview with the Administrator (ADM) on 3/13/24, at 10:14 AM, the ADM stated room [ROOM NUMBER] was 11 x 22 (242 square feet), with a free-standing closet measuring 2 feet 9 inches x 1 foot 11 inches (5.27 square feet), leaving a total of 236.73 square feet for a 3-bed room or 78.9 square feet per resident, less than the 80 square feet required. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	b. During a concurrent observation and interview with Resident 40 (an unsampled resident), on 3/5/24, at 11:32 AM,in room [ROOM NUMBER], bed space 18a was empty. Resident 40 stated his room was fine and he did not have issues with the space provided. Observation of the room indicated there was enough room for Resident 40's personal items and durable medical equipment (DME - wheelchairs, walkers, etc.,). During an interview with Resident 27 (an unsampled resident), on 3/5/24, at 11:35 AM, Resident 27 stated he had enough room for his needs and his wheelchair was not in the way. During a concurrent interview and observation with the MD, on 3/7/24, at 12:35 PM, the MD measured room [ROOM NUMBER] at 14 x17 feet (238 square feet) for a 3-bed room, leaving 79.3 square feet per resident, less than the 80 square feet per resident required. c. During a concurrent observation and interview with Resident 9 (an unsampled resident), on 3/4/24, at 10:28 AM, Resident 9 was in bed. Resident 9 stated she did not have any issues with the size of her room. During a concurrent observation and interview with the MD, on 3/4/24, at 10:35 AM, the MD measured the room, and stated room [ROOM NUMBER], a 3-bed room, measured 231.2 square feet (77.06 square feet per resident), less than the 80 square feet required. d. During a concurrent observation and interview with the MD, on 3/4/24, at 10:39 AM, the MD measured room [ROOM NUMBER] and stated the room was 140 square feet (70 square feet per resident), less that the 80 square feet per resident required. During a concurrent observation and interview with Resident 81, on 3/4/24, at 2:12 PM, Resident 81 stated he had enough room. room [ROOM NUMBER] was a 2-bed room. During an interview with certified nursing assistant (CNA) 3, on 3/7/24, at 9:48 AM, CNA 3 stated they had worked at the facility for over 9 years. CNA 3 explained she did not have any trouble working in the smaller rooms. CNA 3 further explained they feel they are safe, and the residents had not complained about the smaller rooms. During an interview with CNA 4, on 3/7/24, at 9:51 AM, CNA 4 stated he was able to safely do patient care in the smaller rooms. CNA 4 further stated the residents were safe in the smaller rooms and residents and family had not complained about the size of the rooms. During an interview with licensed nurse (LN) 5, on 3/7/24, at 10 AM, LN 5 stated she was able to perform her job safely in the smaller rooms. LN 5 further stated she had not received any complaints from residents residing in the smaller rooms or their family members. Room Waiver recommended to continue, as contingent upon compliance with federal regulations at Resident Rights (481.10) and Physical Environment (483.90).