STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055045	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Healthcare Center	8203 Telegraph Rd Pico Rivera, CA 90660

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the facility failed to obtain an informed consent (process of communication between resident/responsible party and health care provider that often leads to agreement or permission for care, treatment, or services) prior to the administration of psychotropic medication (medications that affect the mind, emotions, and behavior) and the use of bed side rails (metal or plastic bars positioned along the side of a bed for three out of eight sampled residents (Resident 9, 68, and 121). This deficient practice violated Resident 9, 68, and 121's right to make an informed decision prior to the administration of psychotropics and bed siderails. Findings: a. During a review of Resident 9's Admission Record, the admission record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 9's diagnoses included depression (common mental health condition that involves a persistent low mood or loss of interest in activities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's History and Physical (H&P) dated 9/4/2024, the H&P indicated Resident 9 did not have capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS), a resident assessment tool), dated 10/8/2024, the MDS indicated Resident 9's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 9 was dependent on staff for dressing, toileting hygiene, putting on and taking off footwear, personal hygiene, and oral hygiene. During a review of Resident 9's Order Summary Report dated 1/30/2024, the order summary report indicated Resident 9 had an order for mirtazapine 7.5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), one tablet via gastrostomy tube (g-tube, a tube placed through the belly opening and into the stomach for feeding, hydration, and medications) at bedtime for depression, and an order for memantine 5mg, one tablet via g-tube for dementia. During a review Of Resident 9's Medication administration Record (MAR), for the month of November 2024, the MAR indicated Resident 9 received mirtazapine 7.5 mg from 11/1/2024 to 11/14/2024. The MAR indicated Resident 9 also received memantine 5mg from 11/1/224 to 11/15/2024. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's care plan for depression dated 6/18/2024, the care plan indicated Resident 9's goal was for Resident 9 to remain free of signs and symptoms of distress, depression, anxiety (feeling of unease), and a sad mood. The staff's interventions indicated to administer mirtazapine tablet 7.5 mg for depression. During a review of Resident 9's care plan for dementia dated 11/20/2023, the care plan indicated Resident 9's goal was for Resident 9 to maintain a level of activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The staff's interventions indicated to administer memantine tablet 5 mg for dementia. During a review of Resident 9's medical record, unable to locate an informed consent for mirtazapine tablet 7. 5 mg and memantine tablet 5mg. b. During a review of Resident 68's Admission Record, the admission record indicated Resident 68 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 68's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 68's H&P dated 10/1/2024, the H&P indicated Resident 68 had the capacity to understand and make decisions. During a review of Resident 68's MDS, dated [DATE], the MDS indicated Resident 68's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 68 was dependent on staff for toileting hygiene, putting on and taking off footwear, personal hygiene, and oral hygiene. The MDS indicated Resident 68 required maximal assistance (helper does more than half the effort) for eating and upper body dressing. During a review of Resident 68's Order Summary Report dated 10/29/2024, it indicated Resident 68 had an order for ativan tablet, one mg one time a day on Monday, Wednesday, and Friday for anxiety, and an order for zyprexa five mg, one tablet by mouth one time a day for schizophrenia. During a review of Resident 68's MAR for the month of November 2024, the MAR indicated Resident 68 received ativan for anxiety on 11/1/2024, 11/4/2024, 11/6/2024, 11/8/2024, 11/11/2024, and 11/13/2024. The MAR also indicated Resident 68 received zyprexa one time a day for schizophrenia from 11/1/224 to 11/13/2024. During a review of Resident 68's Informed Consent for Zyprexa, dated 9/29/2024, the informed consent did not have the facility's staff signature that verified the informed consent with Resident 68's responsible party. During a review of Resident 68's Informed Consent for Ativan, dated 9/30/2024, the informed consent did not have the facility's staff signature that verified the informed consent with Resident 68's responsible party. During a review of Resident 68's Informed consent for bilateral upper bed side rails, dated 9/29/2024, the informed consent did not have the facility's staff signature that verified the informed consent with Resident 68's responsible party. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. During a review of Resident 121's Admission Record, the admission record indicated Resident 121 was admitted to the facility on [DATE]. Resident 121's diagnoses included anxiety and depression. During a review of Resident 121's H&P dated 3/22/2024, the H&P indicated Resident 121 did not have the capacity to understand and make decisions. During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 121 was dependent on staff for ADLs. During a review of Resident 121's Order Summary Report dated 11/13/2024, the order summary report indicated Resident 121 had an order for lorazepam 2 mg/milliliter ([ml] unit of measurement, used for medication dosage and/or amount), 0.5 ml sublingually (under the tongue) every six hours as needed for anxiety. During a review of Resident 121's care plan for anxiety dated 10/25/2024, the care plan indicated the goal was for Resident 121 to reduce the episodes of anxiousness. The staff's interventions indicated to administer lorazepam 0.5 ml sublingually every six hours as needed for anxiety. During a review of Resident 121's Informed Consent for lorazepam, dated 10/24/2024, the informed consent did not have the signature of the physician that proposed the medication to Resident 121's responsible party. During an interview on 11/15/2024 at 11:28 a.m. with Licensed Vocational Nurse (LVN 4), LVN 4 stated psychotropic medications required an informed consent prior to the administration of medication. LVN 4 stated two licensed nurses must sign the informed consent to verify Resident 121 was informed of the medication therapy. LVN 4 stated an informed consent must have a doctor's signature to demonstrate that the medication therapy was explained to the resident or responsible party. LVN 4 stated the informed consent must be signed by the resident or responsible party to indicate they were informed of the medication therapy. LVN 4 stated these signatures must be present on the informed consent to make it a complete consent. LVN 4 stated if an informed consent was missing a signature, it was invalid and the medication or treatment therapy should not be started. During an interview on 11/15/2024 at 2:12 p.m. with the Assistant Director of Nursing (ADON), the ADON stated an informed consent was complete when a resident or their responsible party, the doctor, and the admitting nurse signed the consent. The ADON stated if there was a signature missing, the therapy should not be initiated. The ADON stated it was important to have a complete consent for resident safety and to inform the resident of the treatments they receive. The ADON stated if a doctor's signature was missing, a licensed nurse could check if there was an order for that treatment and if there was then the licensed nurse could initiate treatment. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Informed Consent, dated 1/2024, the P&P indicated a doctor, physician assistant, or nurse practitioner must obtain an informed consent of the resident or their responsible party for purposes of prescribing, ordering, or increasing an order for a psychotherapeutic medication. The P&P indicated a doctor, physician assistant, or nurse practitioner must obtain an informed consent of the resident or their responsible party for use of bed side rails. The P&P indicated there was a requirement for the facility to renew informed consent every six months even if the dosage was decreased. The P&P indicated the facility would verify that informed consent was obtained prior to the administration of psychotherapeutic medication and for use of side rails. The P&:P indicated it was the responsibility of the physician, physician assistant or nurse practitioner who ordered psychotherapeutic medication to obtain the resident or the responsible party's informed consent prior to the initiation of therapy.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to remove the identifiable health information (any information that could be used to identify the individual, such as the full name, date of birth, etc.) on the gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, for people with swallowing problems) feeding bottle before the disposition in the trash can for one of 11 sampled residents (Resident 100). This deficient practice had the potential to result in unauthorized disclosure of Resident 100's personal information to unauthorized users. Findings: During an observation on 11/12/2024 at 9:16 a.m., in Resident 100's room, Resident 100's GT feeding bottle with the resident's name was observed in the trash can. During a review of Resident 100's Admission Record, the admission record indicated Resident 100 was admitted to the facility on [DATE]. Resident 100's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and hypertension (HTN- high blood pressure). During a review of Resident 100's History and Physical (H&P), dated 10/12/2024, the H&P indicated Resident 100 did not have the capacity to understand and make decisions. During a review of Resident 100's Minimum Data Set (MDS - a resident assessment tool), dated 1/10/2024, the MDS indicated Resident 100's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated Resident 100 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with self-care and mobility. During a review of Resident 100's Oder Summary Report, as of 11/13/2024, the report indicated an order dated 10/31/2024, GT Glucerna 1.5 (a nutrition supplement designed for people with DM or abnormal sugar) rate 70 cubic centimeters (cc, unit of volume) per hour for 20 hours, start at 2 p.m. and stop at 10 a.m. until total volume of 1400 cc was infused. During a concurrent interview and review of a picture of Resident 100's GT feeding bottle on 11/13/2024 at 3:01 p.m. with Licensed Vocational Nurse (LVN) 4, the picture dated 11/12/2024 at 9:16 a.m. was reviewed. The picture indicated the GT feeding bottle with the resident's name was in a trash can in the resident's room. LVN 4 stated because of Health Insurance Portability and Accountability Act (HIPPA, a United States legislation that provided data privacy and security provisions for safeguarding medical information), the licensed nurse needed to take off or blacken out Resident 100's name before disposing the GT feeding bottle in the trash can to protect the resident's privacy. LVN 4 stated it was not acceptable to have Resident 100's name on the GT bottle in the trash can, and all nurses were responsible for ensuring Resident 100's name was removed before the disposition in the trash can. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Quality of life- dignity, revised in 10/2009, the P&P indicated staff shall maintain an environment in which confidential clinical information was protected.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) and/or implement interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) for five of 27 sampled residents (Residents 39, 65, 72, 92, and 130) by failing to: 1. Implement care plan interventions for floor mats for Resident 72. 2. Failed to ensure Resident 39 was kept clean and dry and did not have to wait five and a half hours to be changed or cleaned, per the care plan. 3. Failed reposition Resident 92 every two hours, per the care plan. 4. Develop a care plan for Resident 92's use of Plavix (an antiplatelet medication used to prevent blood clots), lorazepam (also known as Ativan, a medication used to treat anxiety [a feeling of fear, dread, or uneasiness), and morphine sulphate (an pain medication used to treat moderate to severe pain). 5. Develop a care plan for Resident 64's use of Eliquis (a blood thinner used to prevent blood clots) and tramadol (a medication used to treat moderate to severe pain). 6. Develop a care plan for Resident 130's use of escitalopram (a medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]), Ativan, Risperdal (an antipsychotic [medication used to certain mental and mood disorders]), and valproic acid (a medication used to treat certain mental and mood disorders). These deficient practices had the potential to negatively affect Residents 39, 54, 72, 92, and 130's physical, mental, and psychosocial well being and had the potential to delay the delivery of necessary care and services. Findings: a. During a review of Resident 72's admission record, the admission record indicated Resident 72 was admitted to the facility on [DATE]. Resident 72's admitting diagnoses included lack of coordination, generalized muscle weakness, age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 72's History and Physical (H&P), dated 6/24/2024, the H&P indicated Resident 72 had fluctuating capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 72's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/10/2024, the MDS indicated Resident 72 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 72 was dependent on staff for activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility while in and out of bed. During a review of Resident 72's Morse Fall Scale assessment, dated 9/5/2024, the assessment indicated Resident 72 had a score of 55, indicating the resident was at high risk for repeat falls. During a review of Resident 72's physician orders, dated 6/24/2024, the physician orders indicated to provide floor mats to both sides of the bed to minimize potential injury. During a review of Resident 72's care plan dated 10/30/2024, the care plan indicated resident was at risk for falls. The staff's interventions indicated to implement fall interventions specific to the resident. During a concurrent observation and interview on 11/13/2024 at 9:41 a.m., with Resident 72, in Resident 72's room, one floor mat was observed to the right side of Resident 72's bed. There was no floor mat on the left side of her bed. Resident 72 stated she had a history of falls, including falling out of her bed. During an observation on 11/13/2024 at 2:52 p.m., in Resident 72's room, a floor mat was observed on the right side of Resident 72's bed and there was no floor mat on the left side of her bed. During an observation on 11/14/2024 at 8:28 a.m., in Resident 72's room, a floor mat was observed on the right side of Resident 72's bed and there was no floor mat on the left side of her bed. During a concurrent observation and interview on 11/14/2024 at 9:25 a.m., in Resident 72's room, with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 72 only had one floor mat, and it was placed on the right side of the bed. CNA 3 stated there was no floor mat on the left side of the bed. During a concurrent interview and record review, on 11/14/2024 at 9:33 a.m., with Registered Nurse (RN) 1, Resident 72's physician's order dated 6/24/2024 was reviewed . RN 1 stated the physician's order indicated Resident 72 was to have floor mats to both sides of her bed. During a concurrent observation and interview, on 11/14/2024 at 9:35 a.m., in Resident 72's room, with RN 1, RN 1 stated Resident 72 only had a floor mat to one side of her bed, and this did not match Resident 72's physician orders. RN 1 stated that without the floor mat, the resident could fall on the floor and sustain injuries. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk Managing, dated 1/2024, the P&P indicated facility staff were to identify appropriate interventions to reduce the risk of falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Falling Star Program, dated 1/2024, indicated residents with a score of 45 or higher on the Morse Fall Scale assessment were to be placed on the Falling Star Program, and that it was the staff's responsibility to ensure that fall interventions were implemented. 47858 b. During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was originally admitted to the facility on [DATE], with a diagnosis of Stage IV (a full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of the right buttock, left and right heel, and sacral region (tailbone), and adult failure to thrive (gradual decline in a person's ability to perform everyday activities, often due to multiple chronic medical conditions). During a review of Resident 39's MDS dated [DATE], the MDS indicated Resident 39's cognitive skills for daily decision making was intact. The MDS indicated Resident 39 required partial assistance when he ate, and was entirely dependent on staff for ADLs. During a review of Resident 39's Pressure Ulcer Care Plan, initiated 10/11/2024, the Care Plan indicated the facility was to clean Resident 39 after each episode of incontinence and to provide good skin care each shift. During an interview, on 11/12/2024, at 10:00 a.m., with Resident 39, Resident 39 stated that he was usually left soiled for a couple of hours during the 11:00 p.m. to 7:00 a.m. shift. Resident 39 stated that he would push his call light button, but staff would not come to answer the call light. During an interview, 11/13/2024, at 8:50 a.m., with Resident 39, Resident 39 stated that he was upset because he was left soiled from 4:00 a.m. to 9:30 a.m., and that no one came to clean him until he told the treatment nurse. During an interview, on 11/13/2024, at 8:55 a.m., with Resident 339, Resident 339 (Resident 39's roommate) stated that the 11:00 p.m. to 7:00 a.m. staff did not answer Resident 39's call light. During a review of Resident 339's Admission Record, the Admission Record indicated Resident 339 was originally admitted to the facility on [DATE] with a diagnosis of osteomyelitis (infection of the bone) of the left ankle and foot. During a review of Resident 339's MDS, dated [DATE], the MDS indicated that Resident 339's cognitive skills for daily decision making was intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 11/13/2024, at 8:04 a.m., with the Treatment Nurse (TXN), the TXN stated he was responsible for providing the wound treatments for the residents in the facility. The TXN stated it was important that all residents were repositioned and provided timely perineal care (the practice of cleaning the genital and anal areas to maintain personal hygiene) to prevent the development or worsening of pressure ulcers. The TXN stated, earlier that morning, at 9:30 a.m., Resident 39 told him he was soiled and waited to be change since the 11:00 p.m. to 7:00 a.m. shift. The TXN stated that he helped change and clean Resident 39. The TXN stated that it was not acceptable that Resident 39 was left soiled for an extended amount of time, especially because Resident 39 was known to have multiple, extensive pressure ulcers. During a concurrent interview and record review on 11/15/2024, at 12:12 p.m., with RN 2, Resident 39's Pressure Ulcer Care Plan dated 10/11/2024 was reviewed. RN 2 stated that residents with existing pressure injuries should be cleaned right away so that it would allow for the wounds to heal, to prevent worsening of the pressure injuries, and to prevent the risk of infections. RN 2 stated the care plan was not followed. RN 2 stated that the care plan was important to be followed to prevent the worsening of the residents' existing issues. c. During a review of Resident 92's Admission Record, the Admission Record indicated Resident 92 was originally admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the right side. During a review of Resident 92's MDS, dated [DATE], the MDS indicated that Resident 92's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 92 was entirely dependent on staff for ADLs. During an interview, on 11/12/2024, at 9:44 a.m., with Resident 92, Resident 92 stated that he assumed that he had a pressure ulcer because the resident felt some pain to his sacral area. During an interview, on 11/12/2024, at 2:15pm., with CNA 3, CNA 3 stated that she had known Resident 92 to have a scratch on his buttock area. During an oservation on 11/12/2024, at 2:20 p.m., with CNA 3, Resident 92's sacral area was observed. Resident 92 had a reddened open wound, with defined edges on his sacrum. During a review of Resident 92's Change of Condition note, dated 11/12/2024, the note indicated Resident 92 developed moisture-associated skin damage (MASD- moisture associated skin damage caused from prolonged exposure to moisture) to the sacrum. The note indicated Resident 92's physician indicated to be reposition the resident every two hours and as needed. During a review of Resident 92's MASD Care Plan, initiated 11/12/2024, the Care Plan indicated staff's interventions indicated to turn and reposition Resident 92 every two hours as tolerated. During observations made on 11/13/2024, at 8:00 a.m., 10:10 a.m., 12:13 p.m. and 2:15 p.m., Resident 92 was observed positioned on his back. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations made on 11/14/2024, at 12:07 p.m., and 1:55 p.m. Resident 92 was observed positioned on his back. During a concurrent record review and interview, on 11/15/2024, at 12:12 p.m., with RN 2, Resident 92's MASD Care Plan dated 11/12/2024, was reviewed. RN 2 stated the care plan was not followed. RN 2 stated that the care plan was important to be followed to prevent the worsening of the residents' existing issues. During a review of the facility's CNA Job Description (undated), the Job Description indicated that the CNA was to provide routine daily nursing care and services in accordance with the care plan of each resident. During a review of the facility's Policy and Procedure (P&P), titled, Repositioning, dated 1/2024, the P&P indicated that residents who were in bed should have been repositioned frequently or as needed, and for residents with a Stage I or above pressure ulcer, repositioned frequently or as needed. During a review of the facility's P&P, titled, Prevention of Pressure Ulcers/ Injuries, dated 1/2024, the P&P indicated that the facility was to keep the skin clean and free of exposure to urine and fecal matter. 47679 d. During a review of Resident 92's Admission Record, the admission record indicated Resident 92 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to deep vein thrombosis ([DVT], a blood clot that forms in a vein deep in the body) of right lower extremity ([RLE], part of the body that includes the hip, thigh, knee, leg, ankle and foot), major depressive disorder, and dementia (a progressive state of decline in mental abilities). During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92's cognition was severely impaired. The MDS indicated in a two-week period, Resident 92 had little interest in doing things for half or more of the days (seven to 11 days). The MDS indicated Resident 92 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 92 received antianxiety and antiplatelet medication. During a review of Resident 92's History and Physical (H&P), dated 2/21/2024, the H&P indicated Resident 92 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 92's Order Summary Report, dated 1/1/2024 through 11/30/2024, the Order Summary Report indicated the following: 1. Give lorazepam 0.25 milliliters (mL, a unit of measurement), by mouth, every six hours as needed for anxiety and agitation for 30 days. 2. Give morphine sulphate 0.25 mL, sublingually (under the tongue), every four hours as needed for severe pain (rating of 7 through 10 out of 10 on the pain scale). 3. Give Plavix 75 milligrams (mg, unit of measurement), by mouth once a day, for DVT of the RLE. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 92's Medication Administration Record (MAR), dated 11/1/2024 through 11/30/2024, the MAR indicated: 1. Resident 92 received Plavix 75 mg once a day 11/1/2024 through 11/13/2024. 2. Resident 92 received lorazepam 0.25 mL on 11/13/2024. 3. Resident 92 received morphine sulphate 0.25 mL on 11/2/2024. During an interview on 11/14/2024 at 8:47 a.m. with the MDS Coordinator (MDSC), the MDSC stated one of her responsibilities in the facility was to develop residents' care plans based on their assessment on the MDS. The MDSC stated care plans were a tool between providers and caregivers in the facility and were utilized to provide resident-centered care to each resident. The MDSC stated care plans were developed based on a resident's diagnosis, risk factors, and medications. The MDSC stated care plans were developed on medications that had a black box warning (a serious safety warning issued by the United States Food and Drug Administration [FDA] for medications that have a potential for serious adverse reactions) so the staff would be able to recognize any adverse reactions or side effects the resident may experience. The MDSC stated it was important to develop these care plans to monitor the resident properly and implement any other interventions. During a concurrent interview and record review on 11/14/2024 at 8:52 a.m., with the MDSC, Resident 92's medical record was reviewed. There were no care plans that addressed Resident 92's use of lorazepam, morphine sulphate, and Plavix. The MDSC stated there should have been care plans developed for lorazepam, morphine sulphate, and Plavix because each medication was ordered by Resident 92's physician to treat one of Resident 92's condition and each medication required specific monitoring. e. During a review of Resident 65's Admission Record, the admission record indicated Resident 65 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to dementia, major depressive disorder, and DVT of the left lower extremity (LLE). During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65's cognition was severely impaired. The MDS indicated Resident 65 was dependent on staff's assistance with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 65 required maximal assistance (helper does more than half the effort) with eating, oral hygiene, and upper body dressing. The MDS indicated Resident 65 received pro re nata ([PRN], as needed) pain medication. The MDS indicated Resident 65 received anticoagulant and opioid medication. During a review of Resident 65's H&P, dated 9/2/2024, the H&P indicated Resident 65 did not have the capacity to understand and make decisions. During a review of Resident 65's Order Summary Report, active as of 11/14/2024, the Order Summary Report indicated: 1. Give Eliquis 5 mg, by mouth, one time a day for DVT prophylaxis (attempt to prevent disease). 2. Give tramadol 50 mg, by mouth, every eight hours as needed for severe pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 65's MAR, dated 11/1/2024 through 11/30/2024, the MAR indicated: 1. Resident 65 received Eliquis 5 mg once a day 11/1/2024 through 11/13/2024. 2. Resident 65 received tramadol 50 mg on 11/4/2024, 11/6/2024 through 11/12/2024, and 11/14/2024. During a concurrent interview and record review on 11/14/2024 at 8:59 a.m. with the MDSC, Resident 65's medical record was reviewed. There were no care plans that addressed Resident 65's use of Eliquis and tramadol. The MDSC stated Resident 65 should have had care plans developed to address her use of Eliquis and tramadol to ensure any interventions for monitoring would be implemented. f. During a review of Resident 130's Admission Record, the admission record indicated Resident 130 was admitted to the facility on [DATE] with diagnoses that include but not limited to dementia, schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from lows of depression to elevated periods of emotional highs), and major depressive disorder. During a review of Resident 130's MDS, dated [DATE], the MDS indicated Resident 130's cognition was severely impaired. The MDS indicated in a two-week period, Resident 130 felt little interest or pleasure in doing things for half or more of the days. The MDS indicated Resident 130 was dependent on staff's assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 130 received antipsychotic, antianxiety, and antidepressant medication. During a review of Resident 130's H&P, dated 10/11/2024, the H&P indicated Resident 130 had fluctuating capacity to understand and make decisions. During a review of Resident 130's Order Summary Report, active as of 10/10/2024 through 11/30/2024, the Order Summary Report indicated: 1. Give escitalopram 20 mg, via gastrostomy tube ([g-tube], a surgical opening fitted with a device to allow feeding s and medications to be administered directly to the stomach, common for people with swallowing problems), one time a day for depression as manifested by verbalization of feeling sad. 2. Give lorazepam 1 mg, via g-tube, every six hours as needed for anxiety as manifested by restlessness and agitation for 30 days. 3. Give Risperdal 1 mg, via g-tube, two times a day for antipsychotic as manifested by angry outburst. 4. Give Valproic Acid 5 mL, via g-tube, every 12 hours for mood swings as manifested by rapid fluctuations of emotion. During a review of Resident 130's MAR, dated 11/1/2024 through 11/30/2024, the MAR indicated: 1. Resident 130 received escitalopram 20 mg one time a day 11/1/2024 through 11/13/2024. 2. Resident 130 received Valproic Acid 5 mL twice a day 11/6/2024 through 11/13/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 130 received Risperdal 1 mg twice a day 11/8/2024 through 11/13/2024. 4. Resident 130 received lorazepam 1 mg 11/1/2024 through 11/13/2024. During a concurrent interview and record review on 11/14/2024 at 9:01 a.m., with the MDSC, Resident 130's medical records were reviewed. There were no care plans that addressed Resident 130's use of escitalopram, lorazepam, Risperdal, and Valproic Acid. The MDSC stated there should have been care plans developed for Resident 130's use of escitalopram, lorazepam, Risperdal, and Valproic Acid so the nurses could monitor for any adverse reactions. During an interview on 11/14/2024 at 11:53 a.m., with the Director of Nursing (DON), the DON stated care plans were developed to identify any actual or potential problems a resident may have, create goals, and develop interventions that the staff would implement to provide care to the resident. The DON stated care plans were developed for medications, especially those with black box warnings, so the nurses were aware of the potential risks associated with the medications and to take extra precautions. The DON stated care plans would include interventions the staff would have to perform, mainly to monitor for any adverse reactions and to monitor whether the behaviors the medications would treat were getting better or worse. The DON stated without the care plans, the residents' quality of care and quality of life could be affected because the staff would not be alerted of the side effects they need to monitor for. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 1/2024, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to: 1. Revise the care plan when one of 27 sampled residents (Resident 75) did not meet the goals of maintaining her body weight, without additional weight loss. 2. Ensure the Registered Dietician (RD, a healthcare professional who specializes in nutrition and diet) was involved in the care planning for Resident 75's weight loss. These deficient practices increased the potential for Resident 75 to sustain continued and unplanned weight loss. Findings: During a review of Resident 75's Admission Record, the admission record indicated Resident 75 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 75's diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and stroke (loss of blood flow to a part of the brain). During a review of Resident 75's History and Physical (H&P), dated 2/164/2024, the H&P indicated Resident 75 had the capacity to understand and make decisions. During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool), dated 8/10/2024, the MDS indicated Resident 75 had no cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions), and could eat independently. During a review of Resident 75's monthly weights, dated 8/2024 and 9/2024, the weights indicated Resident 75 weighed 260 pounds (lbs., a unit of weight measurement) in 8/2024. The weights indicated Resident 75 weighed 256 lbs. in 9/2024. During a review of Resident 75's Change of Condition (COC) Assessment, dated 9/8/2024, the assessment indicated Resident 75 sustained unplanned weight loss from 8/2024 to 9/2024. The COC indicated Resident 75's physician was notified and ordered for staff to continue to monitor Resident 75's weight and refer her to the RD. During a review of Resident 75's care plan, titled [Resident 75] has weight loss of 4 lbs. in one month, dated 9/8/2024, the care plan indicated Resident 75's goals of care were to maintain her body weight without avoidable change for 30 days. Staff interventions included encouraging and offering increased oral food intake to Resident 75. During a review of Resident 75's monthly weights, dated 9/2024 to 11/2024, the weights indicated Resident 75 continued to sustain weight loss from 9/2024 to 11/2024. Resident 75's weight was 256 lbs. in 9/2024, 253 lbs. in 10/2024, and 252 lbs. in 11/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 8:48 a.m., with the RD, the RD stated Resident 75 was not on a planned weight loss regimen. The RD also stated her first assessment of Resident 75 was on 11/14/2024, and stated she was not previously involved in Resident 75's care. During a concurrent interview and record review, on 11/15/2024 at 11:14 AM, with Registered Nurse (RN) 2, Resident 75's COC assessment dated [DATE], monthly weights from 8/2024 to 11/2024, and care plan dated 9/8/2024 were reviewed. RN 2 stated the COC indicated staff were supposed to monitor Resident 75 for continued weight loss. RN 2 stated Resident 75's monthly weights indicated Resident 75 continued to sustain weight loss. Resident 75 stated the care plan indicated Resident 75 was not supposed to have continued avoidable weight loss, and stated the care plan should have been revised to address Resident 75's continued weight loss. RN 2 stated interventions could have been revised to address the cause of Resident 75's weight loss, including poor oral intake of her meals. During a review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention, revised 1/2024, the P&P indicated care planning for weight loss was a multidisciplinary effort, and was supposed to include input from the RD. The P&P further indicated that the care plan included time frames and parameters for monitoring and reassessment. The P&P indicated the purpose was to prevent, monitor, and intervene for undesirable weight loss.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 signed the Medication Administration Record (MAR) and Pain Assessment Flowsheet immediately after administering Norco (medication used to treat moderate to severe pain) to one of one sampled resident (Resident 104). This deficient practice had the potential to result in the double administration of medication to Resident 104 that could lead to overdose (ingestion of a drug in quantities greater than recommended which could result in death). Findings: During a review of Resident 104's Admission Record (Face Sheet), the admission record indicated Resident 104 was admitted to the facility on [DATE]. Resident 104's diagnosed included dementia (a progressive state of decline in mental abilities), chronic kidney disease (a long-term condition where the kidneys are damaged and can't filter blood properly), and contracture (a stiffening/shortening of any joint, that reduces the joint's range of motion) of the right and left knee. During a review of Resident 104's Minimum Data Set ([MDS], a resident assessment tool), dated 10/10/2024, the MDS indicated Resident 104's cognition (process of thinking) was severely impaired. The MDS indicated Resident 104 required maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 104 was dependent on staff's assistance with bathing and lower body dressing. The MDS indicated Resident 104 received pro re nata ([PRN], as needed) pain medication. The MDS indicated Resident 104 received opioid (used to treat moderate to severe pain) medication. During a review of Resident 104's History and Physical (H&P), dated 1/30/2024, the H&P indicated Resident 104 did not have the capacity to understand and make decisions. During a review of Resident 104's Order Summary Report, active orders as of 11/14/2024, the Order Summary Report indicated to give Norco 10-325 milligrams (mg, unit of measurement), by mouth, every six hours as needed for severe pain. (seven out of 10 pain scale). During a concurrent observation and interview on 11/13/2024 at 11:45 a.m., at Medication Cart 3, with Licensed Vocational Nurse (LVN) 2, Resident 104's bubble pack (a card used to store medications for the resident) for Norco was observed with 23 tablets left in the bubble pack. LVN 2 stated that there were 23 tablets of Norco left in the bubble pack. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/13/2024 at 11:47 a.m., with LVN 2, Resident 104's Medication Count Sheet, undated, was reviewed. The Medication Count Sheet indicated there were six doses (tablets) of Norco administered to Resident 104 with the last dose administered on 11/12/2024 at 9 a. m. The Medication Count Sheet indicated 24 doses should be left in the bubble pack. LVN 2 stated there was a discrepancy between Resident 104's Medication Count Sheet and bubble pack for Norco where the Medication Count Sheet indicated 24 doses of Norco should remain and the bubble pack for Norco only had 23 doses remaining. LVN 2 stated she had administered a dose of Norco to Resident 104 in the morning and she did not mark on the Medication Count Sheet after administering the dose to Resident 104. LVN 2 stated she was supposed to document on the Medication Count Sheet immediately after removing the tablet and administering to Resident 104. During a concurrent interview and record review on 11/13/2024 at 11:48 a.m., with LVN 2, Resident 104's Pain Assessment Flowsheet, undated, was reviewed. The Pain Assessment Flowsheet indicated Resident 104 was last administered Norco on 11/12/2024 for a pain level of eight out of 10 on a pain scale. LVN 2 stated she had not documented on Resident 104's Pain Assessment Flowsheet after administering Norco. LVN 2 stated she was responsible for documenting Resident 104's pain scale rating, location of the pain, and the medication administered after administering the medication. LVN 2 stated pain was part of Resident 104's vital signs and had to be documented to ensure Resident 104's pain was reassessed to ensure the Norco was effective. LVN 2 stated not documenting Resident 104's pain assessment had the potential for incomplete documentation and for the other nurses to be unaware that Resident 104 experienced pain and was administered Norco. LVN 2 stated the Pain Assessment Flowsheet was a communication tool and a way to see how often Resident 104 experienced pain and was treated with pain medication. During a concurrent interview and record review on 11/13/2024 at 11:50 a.m., with LVN 2, Resident 104's Medication Administration Record (MAR), dated 11/1/2024 through 11/30/2024 was reviewed. The MAR indicated Resident 104 was last administered Norco 10-325 mg on 11/12/2024. LVN 2 stated she had not documented on the MAR after administering Norco to Resident 104. LVN 2 stated she was responsible for documenting on the MAR after administering medication to signify that Resident 104 received the medication. LVN 2 stated documenting on the MAR would ensure communication to another nurse the date and time the medication was administered and to prevent an additional dose being administered too early. LVN 2 stated because the administration date and time was not indicated on Resident 104's MAR, Resident 104 was at risk for double dosing of Norco which could result in an overdose. During an interview on 11/14/2024 at 11:44 a.m., with the Director of Nursing (DON), the DON stated licensed nurses were expected to pour, pass, chart, which meant to prepare the medication, administer to the resident, and then document on the necessary documents. The DON stated when a pain medication was administered to a resident, the licensed nurse was responsible for documenting on the Pain Assessment Flowsheet in addition to the MAR. The DON stated documenting the pain assessment would allow the licensed nurse to determine if the pain medication administered was effective when the resident was reassessed. The DON stated LVN 2 was responsible for documenting on Resident 104's Pain Assessment Flowsheet and MAR after administering the Norco. The DON stated documenting on the MAR was their way to show the medication was administered and to communicate to others when the next dose could be given. The DON stated without the proper documentation, an additional dose of Norco could have been administered to Resident 104 and experience an overdose. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 1/2024, the P&P indicated, As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to ensure nursing staff used a communication board for three of 11 sampled residents (Resident 15, 40, and 84) who did not speak the predominant language of the facility, English. This deficient practice had the potential to negatively affect Resident 15, 40, and 84's physical, mental, and psychosocial needs by preventing the residents from communicating with staff and potentially causing missed or delayed care and/or treatments. Findings: a. During a concurrent observation and interview on 11/13/2024 at 12:28 p.m., in Resident 15's room, there was no language board observed in the room. Resident 15 responded to English questions in Spanish. Resident 15's family member was at the bedside and stated Resident 15 only spoke Spanish. During a review of Resident 15's Admission Record, dated 11/13/2024, the admission record indicated Resident 15 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included sepsis (a life-threatening blood infection), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), anemia (a condition where the body did not have enough healthy red blood cells), and dementia (a progressive state of decline in mental abilities). During a review of Resident 15's History and Physical (H&P), dated 11/13/2024, the H&P indicated Resident 15's did not have the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 7/8/2024, the MDS indicated Resident 15's cognitive skills for daily decision making was intact (ability to think, remember and reason). The MDS indicated Resident 15 was independent (residents completed the activity by themselves with no assistance from a helper) with self-care, indoor mobility, and functional cognition. The MDS indicated Resident 15 required partial assistance (helper did less than half the effort) in toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear, rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfer, and toilet transfer. The MDS indicated Resident 15's preferred language was Spanish and needed an interpreter to communicate with a doctor or health care staff. During a review of Resident 15's care plan titled, Primary language is Spanish, revised on 11/14/2024, the care plan interventions indicated staff were to provide a communication board in Resident 15's primary language. During a concurrent observation and interview on 11/13/2024 at 2:45 p.m. with Certified Nursing Assistant (CNA) 2, in Resident 15's room, there was no language board observed in the room. CNA 2 stated Resident 15 should have a language board because Resident 15 only spoke Spanish. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a concurrent observation and interview on 11/12/2024 at 10:38 a.m., in Resident 84's room, there was no language board observed in the room. Resident 84 spoke limited English and was unable to continue the interview in English. During a review of Resident 84's Admission Record, dated 11/13/2024, the admission record indicated Resident 84 was originally admitted to the facility on [DATE]. Resident 84's diagnoses included hepatic failure (occurred when the liver was unable to perform its normal functions), dysphagia (difficulty swallowing), hypertension (HTN - high blood pressure), chest pain, and anemia. During a review of Resident 84's H&P, dated 7/1/2024, the H&P indicated Resident 84 had the capacity to understand and make decisions. During a review of Resident 84's MDS, dated [DATE], The MDS indicated Resident 84's cognitive skills for daily decision making was intact. The MDS indicated Resident 84 required supervision or touching assistance with showering, tub/ shower transfer, and walking 150 feet. the MDS indicated Resident 84's preferred language was Spanish and needed an interpreter to communicate with a doctor or health care staff. During a review of Resident 84's care plan titled, Primary language is Spanish, revised on 11/13/2024, the care plan interventions indicated staff were to provide a communication board in Resident 84's primary language. During a concurrent observation and interview on 11/13/2024 at 2:42 p.m. with CNA 2, in Resident 84's room, there was no language board observed in the room. CNA 2 stated Resident 84 should have a language board because Resident 84 did not speak English and needed a Spanish translator. CNA 2 stated staff needed the Spanish language board to communicate with Resident 84 to check if the resident was doing fine and to meet the resident's needs. Resident 84 stated he did not speak English. CNA 2 stated it would delay necessary care if there was no language board for Resident 84. c. During a review of Resident 40's Admission Record, dated 11/13/2024, the admission record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included generalized muscle weakness, end stage renal disease (ESRD - irreversible kidney failure), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia, and dementia. During a review of Resident 40's H&P, dated 7/31/2024, the H&P indicated Resident 40's had fluctuating capacity (when a person's ability to make decisions varied over time) to understand and make decisions. During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 40 was dependent (helper did all the effort) with mobility, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, and personal hygiene. The MDS indicated Resident 40 had impairment on the lower extremities and used wheelchair for mobility device. The MDS indicated Resident 40's preferred language was Spanish and needed an interpreter to communicate with a doctor or health care staff. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 40's care plan titled, Primary language is Spanish, revised on 11/13/2024, the care plan interventions indicated staff were to provide a communication board in Resident 40's primary language. During a concurrent observation and interview on 11/13/2024 at 2:47 p.m. with CNA 2, in Resident 40's room, there was no Spanish language board observed in the room. CNA 2 stated Resident 40 should have a Spanish language board because Resident 40 was more fluent in Spanish and only spoke English if he wanted to. During a concurrent observation and interview on 11/14/2024 at 9:34 a.m. with Licensed Vocational Nurse (LVN) 4, in Resident 40's room, there was no Spanish language board observed in the room. LVN 4 stated even though Resident 40 could communicate with both English and Spanish, Resident 40 still needed a Spanish language board in the room. During a review of the facility's Policy and Procedure (P&P) titled, Interpreter Services, revised in 6/2019, the P&P indicated, Communication boards will be provided at no charge to the resident so that non-English speakers, or aphasic residents can use pictograms (a symbol and/or picture that represented a concept, word or instruction) to communicate needs and desires.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to ensure dependent residents were taken out of bed, for three out of eight sampled residents (Resident 5, 14, and 121). This deficient practice had the potential to negatively affect Resident 5, 14, 121's wellbeing, psychosocial status, and potentially cause an isolation of the residents. Findings: 1. During an observation on 11/12/2024 at 11:30 a.m., in Resident 121's room, Resident 121 was observed lying in bed watching television. During an observation on 11/13/2024 at 11:31 a.m., in Resident 121's room, Resident 121 was observed lying in bed watching television. During an observation on 11/14/2024 at 10:48 a.m. and at 3:12 p.m., in Resident 121's room, Resident 121 was observed lying in bed watching television. During an observation on 11/15/2024 at 11:14 a.m., in Resident 121's room, Resident 121 was observed lying in bed watching television. During a review of Resident 121's Admission Record, the admission record indicated Resident 121 was admitted to the facility on [DATE]. Resident 121's diagnoses included anxiety (feeling of unease) and depression (a common mental health condition that involves a persistent low mood or loss of interest in activities). During a review of Resident 121's History and Physical (H&P) dated 3/22/2024, the H&P indicated Resident 121 did not have the capacity to understand and make decisions. During a review of Resident 121's Minimum Data Set (MDS, a resident assessment tool) dated 10/30/2024, the MDS indicated Resident 121's cognitive skills for daily decision making was severely impaired (ability to think and reason). The MDS indicated Resident 121 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 121's ADL Flowsheet, dated 11/2024, the flowsheet indicated from 11/1/2024 to 11/14/2024 Resident 121 was not transferred out of bed. 2. During an observation on 11/12/2024 at 2:50 p.m., in Resident 5's room, Resident 5 was observed lying on her bed. During an observation on 11/13/2024 at 8:25 a.m. and at 12:50 p.m., in Resident 5's room, Resident 5 was observed lying on her bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/14/2024 at 12:05 p.m. and 3:36 p.m., in Resident 5's room, Resident 5 was observed lying on her bed. During an observation on 11/15/2024 at 1:40 p.m., in Resident 5's room, Resident 5 was observed lying in bed. During a review of Resident 5's Admission Record, the admission record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 5's diagnoses included major depressive disorder (a progressive state of decline in mental abilities) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 5's H&P dated 6/6/2024, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 5 required maximal assistance (helper does more than half the effort) for dressing, toileting hygiene, putting and taking off footwear, personal hygiene, and oral hygiene. During a review of Resident 5's Activities of Daily Living (ADL) Flowsheet, for the month of October 2024, the flowsheet indicated from 10/1/2024 to 10/31/2024 Resident 5 was transferred out of bed on 10/1/2024, 10/4/2024, 10/11/2024, 10/18/2024, and on 10/28/2024. During a review of Resident 5's ADL Flowsheet, for the month of November 2024, the flowsheet indicated from 11/1/2024 to 11/14/2024 Resident 5 was not transferred out of bed. 3. During an observation on 11/12/2024 at 3:40 p.m., in Resident 14's room, Resident 14 was observed lying on her bed. During an observation on 11/13/2024 at 8:13 a.m. and at 12:47 p.m., in Resident 14's room, Resident 14 was observed lying on her bed. During an observation on 11/14/2024 at 11:22 a.m., in Resident 14's room, Resident 14 was observed lying on her bed. During an observation on 11/15/2024 at 1:20 p.m., in Resident 14's room, Resident 14 was observed lying in bed watching television. During a review of Resident 14's Admission Record, the admission record indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 14's diagnoses included anxiety disorder and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left side of Resident 14's body. During a review of Resident 14's H&P dated 8/9/2024, the H&P indicated Resident 14 had the capacity to understand and make decisions. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 14 was dependent on staff for eating, toileting hygiene, putting on and taking off footwear, dressing, personal hygiene, and oral hygiene. During a review of Resident 14's ADL Flowsheet, for the month of October 2024, the flowsheet indicated from 10/1/2024 to 10/31/2024 Resident 14 was not transferred out of bed. During a review of Resident 14's ADL Flowsheet, for the month of November 2024, the flowsheet indicated from 11/1/2024 to 11/14/2024 Resident 14 was not transferred out of bed. During an interview on 11/15/2024 at 11:28 a.m. with Licensed Vocational Nurse (LVN 3), LVN 3 stated it was up to the resident when they wanted to get out of bed. LVN 3 stated the staff did not pressure residents to get out of bed if they did not want to. LVN 4 stated the purpose of taking residents out of bed was for the residents to socialize and interact with other residents and prevent the resident from getting bored. LVN 4 stated if residents did not get out of bed it could potentially cause the resident to become depressed and potentially develop skin issues. During an interview on 11/15/2024 at 1:55 p.m. with the Director of Staff Development (DSD), the DSD stated it was a healthy practice to get residents out of bed. The DSD stated the facility allowed residents to pick when they wanted to get out of bed. The DSD stated it was important for residents to get out of bed to prevent depression, isolation and help with offloading pressure to the residents' body. The DSD stated she expected certified nursing assistants (CNAs) to take residents out of bed to attend activities as much as possible. During an interview on 11/15/2024 at 1:55 p.m. with the Assistant Director of Nursing (ADON), the ADON stated staff should offer all residents to get out of bed every day. The ADON stated it was important to take residents out of bed to help their circulation, provide a change in environment, and provide an opportunity to socialize. The ADON stated if residents did not get out of bed, it could potentially lead to depression.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure interventions to prevent formation and/or worsening of pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) were implemented for nine of 27 sampled residents (Residents 39, 92, 24, 83, 72, 6, 19, 120, and 130) when the following occurred: 1. Resident 24's low-air-loss mattress (LALM, an air mattress that's designed to help prevent and treat pressure ulcers) settings did not reflect Resident 24's weight, and Treatment Nurse (TN) 1 failed to clarify Resident 24's LALM orders with Resident 24's physician. 2. Resident 72's LALM settings did not reflect Resident 72's weight. 3. Resident 83's LALM settings did not reflect Resident 83's weight. 4. Failed to ensure Resident 39 was kept clean and dry and did not have to wait five and a half hours to be changed or cleaned. 5. Failed to ensure Resident 92 was repositioned every two hours as indicated in his care plan. 6. Resident 130's LALM settings did not reflect Resident 130's weight. 7. Failed to ensure the correct setting for Resident 6's LALM. 8. Failed to ensure the correct setting for Resident 120's LALM. 9. Resident 19's LALM settings did not reflect Resident 19's weight. These deficient practices placed Residents 39, 92, 24, 83, 72, 6,19, 120, and 130 at risk for worsened condition of their existing pressure ulcers, and/or the development of new pressure ulcers. Findings: 1. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 24's admitting diagnoses included a pressure ulcer to the tailbone area and quadriplegia (inability to from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 24's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/15/2024, the MDS indicated Resident 24 did not have cognitive impairments (problems with a person's ability to think, learn, remember, use judgement, and make decisions) and was dependent on staff for activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility. The MDS indicated Resident 24 was at high risk for developing pressure ulcers, had an existing stage 3 pressure ulcer (a deep wound that involves full thickness tissue loss, but does not expose bone, tendon, or muscle), and used a pressure relieving device. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 24's progress note, dated 10/2/2024, the progress note indicated Resident 24 had a Stage 3 pressure ulcer. The progress note indicated Resident 24 required continued use of a LALM for skin management. During a review of Resident 24's physician order, dated 7/16/2024, the order indicated Resident 24 was supposed to have a LALM kept at setting 2. During a review of Resident 24's body weight, taken on 11/1/2024, Resident 24's body weight was 161 pounds (lbs., a unit of weight measurement). During an observation on 11/12/2024 at 9:26 a.m., at Resident 24's bedside, Resident 24 was observed on a LALM set for 50 lbs. (setting 1). During an observation on 11/13/2024 at 9:11 a.m., at Resident 24's bedside, Resident 24 was observed on a LALM set for 50 lbs. (setting 1). During an observation on 11/13/2024 at 2:50 p.m., at Resident 24's bedside, Resident 24 was observed on a LALM set for 50 lbs. (setting 1). During a concurrent observation and interview on 11/14/24 at 10:51 a.m., with TN 1, photos of Resident 24's LALM settings on 11/13/2024 were reviewed. TN 1 stated Resident 24's most recent weight was 161 lbs., and stated Resident 24's LALM was not effective if set for 50 lbs. (setting 1). TN 1 further stated Resident 24's physician order to keep the LALM at setting 2 was not appropriate either because setting 2 was for 100 lbs., which did not reflect Resident 24's weight. TN 1 stated the LALM order should have been clarified with the physician. TN 1 stated that Resident 24's LALM should not have been set for 50 lbs. (setting 1), and stated the incorrect settings could negatively impact Resident 24's wound. 2. During a review of Resident 72's Admission Record, the Admission Record indicated Resident 72 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 72's admitting diagnoses included a stage 4 pressure ulcer (the most severe type of pressure ulcer, extending through to the muscle, tendon, or bone) to her tailbone area. During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72 had severe cognitive impairments and was dependent on staff for activities of daily living and mobility. The MDS indicated Resident 72 was at high risk for developing pressure ulcers, had an existing stage 4 pressure ulcer, and used a pressure relieving device. During a review of Resident 72's progress note, dated 10/2/2024, the progress note indicated Resident 72 had a stage 4 pressure ulcer. The progress note indicated Resident 72 required continued use of a LALM for skin management. During a review of Resident 72's physician order, dated 6/25/2024, the order indicated Resident 72 was supposed to have a LALM kept at setting 2. During a review of Resident 72's body weight, taken on 11/1/2024, Resident 72's body weight was 137 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/13/2024 at 9:42 a.m., at Resident 72's bedside, Resident 72 was observed on a LALM set for 600 lbs. to 1000 lbs. During an observation on 11/13/2024 at 2:52 p.m., at Resident 72's bedside, Resident 72 was observed on a LALM set for 600 lbs. to 1000 lbs. During a concurrent observation and interview on 11/14/24 at 10:56 a.m., with TN 1, photos of Resident 72's LALM settings on 11/13/2024 were observed. TN 1 stated Resident 72's most recent weight was 137 lbs., and stated Resident 72's LALM was not effective if set for range of 600 to 1000 lbs. TN 1 stated that Resident 72's LALM should have been set for 250 lbs. or less, which was the lowest setting on the machine, and stated the incorrect settings could negatively impact Resident 72's wound. 3. During a review of Resident 83's Admission Record, the Admission Record indicated Resident 83 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 83's admitting diagnoses included hemiplegia and hemiparesis (total inability to move the arm, leg, and trunk on the same side of the body), stage 3 pressure ulcer to the right heel, and generalized muscle weakness. During a review of Resident 83's MDS, dated [DATE], the MDS indicated Resident 83 had moderate cognitive impairments and was dependent on staff for activities of daily living and mobility. The MDS indicated Resident 83 was at high risk for developing pressure ulcers and used a pressure relieving device while in bed. During a review of Resident 83's physician order, dated 7/26/2024, the order indicated Resident 83 was supposed to have a LALM kept at setting 2. During a review of Resident 83's care plan titled [Resident 83] is high risk for developing pressure sore, bruising, and other types of skin breakdown, most recently revised on 11/14/2024, goals of care included minimizing Resident 83's risk of skin breakdown. Care plan interventions indicated Resident 83 was supposed to have pressure relieving devices as ordered. During a review of Resident 83's care plan titled [Resident 83] with LALM use, most recently revised on 8/14/2024, goals of care included minimizing Resident 83's risk of skin breakdown. Care plan interventions included use of a LALM for skin management. During a review of Resident 83's body weight, taken on 10/1/2024, Resident 83's body weight was 135 lbs. During an observation on 11/12/2024 at 3:19 p.m., at Resident 83's bedside, Resident 83 was observed on a LALM set for 350 lbs. During an observation on 11/13/2024 at 9:18 a.m., at Resident 83's bedside, Resident 83 was observed on a LALM set for 350 lbs. During an observation on 11/13/2024 at 2:53 p.m., at Resident 83's bedside, Resident 83 was observed on a LALM set for 350 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/14/2024 at 8:31 a.m., at Resident 83's bedside, Resident 83 was observed on a LALM set for 150 lbs. During a concurrent observation and interview on 11/14/2024 at 11:01 a.m., with TN 1, photos of Resident 83's LALM settings from 11/13/2024 and 11/14/2024 were observed. TN 1 stated that if a resident was between two weight settings on the LALM, they select the lower weight setting. TN 1 stated the settings for 150 lbs. and 350 lbs. were not correct for Resident 83. TN 1 stated Resident 83 used to have a pressure ulcer, and stated that the use of incorrect LALM settings for Resident 83 increased the risk for development Resident 83 to develop repeat pressure ulcers. 47858 4. During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was originally admitted to the facility on [DATE], with diagnoses including Stage IV pressure ulcers of the right buttock, left and right heel, and sacral region, and adult failure to thrive (gradual decline in a person's ability to perform everyday activities, often due to multiple chronic medical conditions). During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39's cognitive skills for daily decision making were intact. The MDS indicated Resident 39 required partial assistance with eating and was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 39's Pressure Ulcer Care Plan, initiated 10/11/2024, the Care Plan indicated the facility was to clean Resident 39 after each episode of incontinence (inability to control bowel and bladder functions) and to provide good skin care each shift. During an interview, on 11/12/2024, at 10:00 a.m., with Resident 39, Resident 39 stated that he was usually left soiled for a couple of hours during the 11:00 p.m. to 7:00 a.m. shift. Resident 39 stated that he would push his call light button, but staff would not come to answer the call light. During an interview, on 11/13/2024, at 8:50 a.m., with Resident 39, Resident 39 stated that he was upset because he was left soiled from 4:00 a.m. to 9:30 a.m., and that no one came to clean Resident 39 until he told the treatment nurse. During an interview, on 11/13/2024, at 8:55 a.m., with Resident 339, Resident 339 (Resident 39's roommate) stated that the 11:00 p.m. to 7:00 a.m. staff did not answer Resident 39's call light. During a review of Resident 339's Admission Record, the Admission Record indicated Resident 339 was originally admitted to the facility on [DATE], with a diagnosis of osteomyelitis (infection of the bone) of the left ankle and foot. During a review of Resident 339's MDS, dated [DATE], the MDS indicated that Resident 339's cognitive skills for daily decision making was intact. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 11/13/2024, at 8:04 a.m., with TN 1, TN 1 stated he was responsible for providing the wound treatments for the residents in the facility. TN 1 stated it was important that all residents were repositioned and provided timely perineal care (the practice of cleaning the genital and anal areas to maintain personal hygiene) to prevent the development or worsening of pressure ulcers. TN 1 stated, earlier that morning (11/13/2024), at 9:30 a.m., Resident 39 told him he was soiled and waited to be change since the 11:00 p.m. to 7:00 a.m. shift. TN 1 stated he helped change and clean Resident 39. TN 1 stated it was not acceptable that Resident 39 was left soiled for an extended amount of time, especially because Resident 39 was known to have multiple, extensive pressure ulcers. During an interview, on 11/15/2024, at 12:12 p.m., with Registered Nurse (RN) 1, RN 1 stated residents with existing pressure injuries should be cleaned right away so that it would allow for the wounds to heal, to prevent worsening of the pressure injuries, and to prevent the risk of infections. 5. During observations made on 11/13/2024 at 8:00 a.m., 10:10 a.m., 12:13 p.m. and 2:15 p.m., Resident 92 was observed positioned on his back. During a review of Resident 92's Admission Record, the Admission Record indicated Resident 92 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident 92's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the right side. During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 92 was entirely dependent on staff for ADLs. During an interview, on 11/12/2024, at 9:44 a.m., with Resident 92, Resident 92 stated he assumed he had a pressure ulcer because he felt some pain to his sacral area. During an interview, on 11/12/2024, at 2:15pm., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she had known Resident 92 to have a scratch on his buttock area. During a concurrent observation and interview, on 11/12/2024, at 2:20 p.m., with CNA 1, Resident 92's sacral area was observed. Resident 92 had a reddened open wound with defined edges on his sacrum. During a review of Resident 92's Change of Condition note, dated 11/12/2024, the note indicated Resident 92 developed moisture-associated skin damage (MASD- moisture associated skin damage caused from prolonged exposure to moisture) to the sacrum. The physician indicated Resident 92 was to be repositioned every two hours and as needed. During a review of Resident 92's MASD Care Plan, initiated 11/12/2024, the Care Plan indicated the staff's interventions indicated to turn and reposition Resident 92 every two hours as tolerated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Healthcare Center	8203 Telegraph Rd Pico Rivera, CA 90660

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/15/2024, at 12:12 p.m., with RN 1, RN 1 stated residents that have limited bed mobility should have been repositioned every two hours, or when the resident felt uncomfortable in bed. RN 1 stated that if Resident 92 was not repositioned every two hours, there was a potential for Resident 92's skin impairment to lead to a pressure injury and an increased risk of infection related to the wound. 49900 6. During an observation on 11/12/2024 at 10:00 a.m., in Resident 130's room, Resident 130 was observed lying on a LALM. The LALM was set for a resident that weighed 320 lbs. (setting 8). During a review of Resident 130's Admission Record, the admission record indicated Resident 130 was admitted to the facility on [DATE]. Resident 130's diagnoses included Stage IV pressure ulcer, anemia, dementia (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that was characterized by disturbances in thought). During a review of Resident 130's H&P, dated 10/11/2024, the H&P indicated Resident 130 had fluctuating capacity (situations where a person's decision-making ability varied) to understand and make decisions. During a review of Resident 130's MDS, dated [DATE], the MDS indicated Resident 130's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 130 had no impairment on extremities and was dependent on staff for self-care and mobility. The MDS indicated Resident 130 had three Stage IV pressure ulcers, six unstageable (when the stage was not clear, and the base of the wound was covered by a layer of dead tissue that might be yellow, grey, green, brown, or black) pressure ulcers, and a pressure reducing device for the bed. During a review of Resident 130's Order Summary Report as of 11/13/2024, the report indicated an order, dated 10/11/2024, LALM for wound management and keep setting at 2. During a review of Resident 130's care plan titled, Resident was admitted with pressure injury Stage IV, revised on 10/31/2024, the care plan indicated LALM as ordered. During a review of Resident 130's Weights and Vitals Summary, dated 11/13/2024, the summary indicated Resident 130 weighed 126 lbs. on 11/7/2024. During a concurrent observation and interview on 11/13/2024 at 3:18 p.m. with TN 1, Resident 130's LALM was observed. The LALM indicated the LALM was set for a resident that weighed 320 lbs. (setting 8). TN 1 stated the LALM pump should be set 120 lbs. (setting 2). 7. During an observation on 11/12/2024 at 11:25 a.m., in Resident 6's room, Resident 6 was observed lying on a LALM. The LALM indicated the LALM was set for a comfort level six (setting 6). During a review of Resident 6's Admission Record, the admission record indicated Resident 6 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident 6's diagnoses included generalized muscle weakness, Stage IV pressure ulcers, diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and anemia (a condition where the body did not have enough healthy red blood cells). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's H&P, dated 5/7/2024, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was intact. The MDS indicated Resident 6 was dependent on staff for self-care and mobility. The MDS indicated Resident 6 had two Stage IV pressure ulcers and one unstageable pressure ulcer. The MDS further indicated Resident 6 had a pressure reducing device for the bed. During a review of Resident 6's Order Summary Report as of 11/13/2024, the report indicated an order, dated 10/16/2024, for LALM for wound management and to keep the setting at one. During a review of Resident 6's care plan titled, readmitted with Stage 4 pressure injury, revised on 10/30/204, the care plan indicated to keep LALM setting at one. During a concurrent observation and interview on 11/13/2024 at 3:30 p.m. with TN 1, Resident 6's LALM pump was observed in Resident 6's room. The LALM setting indicated comfort level six (setting 6). TN 1 stated the LALM pump should be set to level one (setting 1), but it was set to level six (setting 6). 8. During an observation on 11/12/2024 at 11:28 a.m., in Resident 120's room, Resident 120 was observed lying on a LALM. The LALM was set for a comfort level five (setting 5). During a review of Resident 120's Admission Record, the record indicated Resident 120 was admitted to the facility on [DATE]. Resident 120's diagnoses included pressure-induced deep tissue damage (also known as deep tissue injury (DTI), purple localized area of discolored intact skin or blood?filled blister due to damage of underlying soft tissue from pressure) of the sacral region, generalized muscle weakness, generalized edema (swelling), dementia, and schizophrenia. During a review of Resident 120's H&P, dated 4/30/2024, the H&P indicated Resident 120 had fluctuating capacity to understand and make decisions. During a review of Resident 120's MDS, dated [DATE], the MDS indicated Resident 120's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 120 was dependent on staff for self-care and mobility. The MDS indicated Resident 120 had one or more unhealed pressure ulcers and two unstageable pressure ulcers presetting as DTI. The MDS further indicated Resident 120 had a pressure reducing device for the bed. During a review of Resident 120's Order Summary Report as of 11/13/2024, the report indicated an order, dated 8/15/2024, LALM for wound management and to keep the setting at three. During a concurrent observation and interview on 11/13/2024 at 3:30 p.m. with TN 1, Resident 120's LALM pump was observed in Resident 120's room. The LALM pump indicated comfort level five (setting 5). TN 1 stated the LALM pump should be set to level three (setting 3), but it was set to level five (setting 5). 9. During an observation on 11/12/2024 at 11:30 a.m., in Resident 19's room, Resident 19 was observed lying on a LALM. The LALM indicated the LALM was set for a resident that weighed 210 lbs. (setting 5). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Admission Record, the record indicated Resident 19 was admitted to the facility on [DATE], with diagnosis of Stage IV pressure ulcers, anemia, dementia, and schizophrenia. During a review of Resident 19's H&P, dated 7/24/2024, the H&P indicated Resident 19 did not have the capacity to understand and make decisions. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 19 was dependent on staff for self-care and mobility. The MDS indicated Resident 19 had one Stage IV pressure ulcer and a pressure reducing device for the bed. During a review of Resident 19's Order Summary Report as of 11/13/2024, the report indicated an order, dated 7/24/2024, to provide LALM for wound management and keep the setting at two. During a review of Resident 19's Weights and Vitals Summary, dated 11/13/2024, the summary indicated Resident 19 weighed 75 lbs. on 11/1/2024. During a concurrent observation and interview on 11/13/2024 at 3:33 p.m. with TN 1, Resident 19's LALM pump was observed in Resident 19's room. The LALM was set for a resident that weighed 210 lbs. (setting 5). TN 1 stated the LALM pump should be set 80 lbs. (setting 1). During an interview on 11/14/2024 at 9:40 a.m., with TN 2, TN 2 stated that LALMs were used for wound management, and stated it was important to set the Resident's weight accurately to assist with wound healing. TN 2 stated that the higher the setting on the LALM, the harder the mattress. TN 2 stated that if the weight setting was too high, and did not reflect the resident's weight, it defeated the purpose of the mattress and could negatively affect wound healing. During a review of the facility's policy and procedure (P&P) titled, Powered Pressure Reducing Air Mattress/Support Services, revised 1/2024, the P&P indicated pressure reducing support surfaces included LALMs, and were used for the care of pressure ulcers. During a review of the facility's P&P titled, Prevention of Pressure Ulcers/ Injuries, dated 1/2024, the P&P indicated staff were to select the appropriate support surfaces (LALM) based on the resident's weight. The P&P indicated the facility was to keep the skin clean and free of exposure to urine and fecal matter. During a review of the facility's P&P titled, Repositioning, dated 1/2024, the P&P indicated that residents who were in bed should have been repositioned frequently or as needed, and for residents with a Stage I or above pressure ulcer, repositioned frequently or as needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure that floor mats (a cushioned floor pad designed to help prevent injury should a person fall) were placed on both sides of the bed for one of 27 sampled residents (Resident 72). This deficient practice increased the potential for Resident 72, who had a history of falls, to sustain injury from repeat subsequent falls. Findings: During a review of Resident 72's Admission Record, the admission record indicated Resident 72 was admitted to the facility on [DATE]. Resident 72's admitting diagnoses included lack of coordination, generalized muscle weakness, age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 72's History and Physical (H&P), dated 6/24/2024, the H&P indicated Resident 72 had fluctuating capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS, a resident assessment tool), dated 9/10/2024, the MDS indicated Resident 72 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 72 was dependent on facility staff for activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility while in and out of bed. During a review of Resident 72's physician orders, dated 6/24/2024, the physician orders indicated floor mats to both sides of Resident 72's bed to minimize potential injury. During a review of Resident 72's Morse Fall Scale assessment, dated 9/5/2024, the assessment indicated Resident 72 had a score of 55, indicating she was at high risk for repeat falls. During a review of Resident 72's care plan titled [Resident 72] is included in the Falling Star Program, dated 10/30/2024, the care plan indicated the resident was at risk for falls. The staff interventions indicated to implement fall interventions specific to the resident. During a concurrent observation and interview on 11/13/2024 at 9:41 a.m., with Resident 72, in Resident 72's room, one floor mat was observed to the right side of Resident 72's bed. There was no floor mat observed on the left side of the bed. Resident 72 stated she had a history of falls, including falling out of her bed. During an observation on 11/13/2024 at 2:52 p.m., in Resident 72's room, a floor mat was observed on the right side of Resident 72's bed and there was no floor mat on the left side of her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/14/2024 at 8:28 a.m., in Resident 72's room, a floor mat was observed on the right side of Resident 72's bed and there was no floor mat on the left side of her bed. During an interview on 11/14/2024 at 9:25 a.m., in Resident 72's room, with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 72 only had one floor mat, and it was placed on the right side of the bed. CNA 3 stated there was no floor mat on the left side of the bed. During a concurrent interview and record review, on 11/14/2024 at 9:33 a.m., with Registered Nurse (RN) 1, Resident 72's physician orders dated 6/24/2024, were reviewed. RN 1 stated the physician orders indicated Resident 72 was supposed to have floor mats to both sides of her bed. During a concurrent observation and interview, on 11/14/2024 at 9:35 a.m., in Resident 72's room, with RN 1, RN 1 stated Resident 72 only had a floor mat to one side of her bed, and this did not match Resident 72's physician orders. RN 1 stated that without the floor mat, the resident could fall on the floor and sustain injuries. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk Managing, dated 1/2024, the P&P indicated facility staff were supposed to identify appropriate interventions to reduce the risk of falls. During a review of the facility's P&P titled Falling Star Program, dated 1/2024, indicated residents with a score of 45 or higher on the Morse Fall Scale assessment were to be placed on the Falling Star Program, and that it was the staff's responsibility to ensure that fall interventions were implemented.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to: 1. Ensure salt alternative seasoning (a product that can be used in place of salt [sodium chloride]) was available for and provided to one of 27 sampled residents (Resident 75), who was on a no added salt (NAS) diet. 2. Refer Resident 75 to the Registered Dietician (RD, a healthcare professional who specializes in nutrition and diet) as ordered by the physician on 9/8/2024. 3. Revise the care plan for Resident 75's weight loss between 8/2024 and 9/2024, when she continued to sustain weight loss. These deficient practices resulted in Resident 75's complaints of unappetizing and flavorless meals, and a self-reported decreased intake of facility-provided meals. These deficient practices also created the potential for Resident 75 to sustain continued unplanned and undesirable weight loss, possibly rising to the level of significant or severe weight loss, following her weight loss of 14 pounds (lbs., a unit of weight measurement) from 6/2024 to 11/2024. Findings: During a review of Resident 75's admission record, the admission record indicated Resident 75 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 75's admitting diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and stroke (loss of blood flow to a part of the brain), and high blood pressure. During a review of Resident 75's History and Physical (H&P), dated 2/164/2024, the H&P indicated Resident 75 had the capacity to understand and make decisions. During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool), dated 8/10/2024, the MDS indicated Resident 75 had no cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions), and could eat independently. During a review of Resident 75's physician's order, dated 10/30/2023, the order indicated to provide Resident 75 a NAS diet. During a review of Resident 75's monthly weights, dated 6/2024 to 8/2024, the weights indicated Resident 75 went from 266 lbs. on 6/1/2024, to 263 lbs. on 7/1/2024, to 260 lbs. on 8/1/2024. During a review of Resident 75's Interdisciplinary (IDT, group of different disciplines working together towards a common goal of a resident) Care Conference Record, dated 8/6/2024, the record indicated there were no dietary staff present. The record did not indicate Resident 75 was on a weight loss plan. The record did not indicate the care team addressed Resident 75's weight loss from 6/2024 to 8/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 75's monthly weights, dated 8/2024 to 9/2024, the weights indicated Resident 75 went from 260 lbs. on 8/1/2024 to 256 lbs. on 9/1/2024. During a review of Resident 75's Change of Condition (COC) Assessment, dated 9/8/2024, the assessment indicated Resident 75 had sustained unplanned weight loss from 8/2024 to 9/2024. The COC indicated Resident 75's physician was notified and ordered for staff to continue to monitor Resident 75's weight and refer her to the RD. During a review of Resident 75's care plan, titled [Resident 75] has weight loss of 4 lbs. in one month, dated 9/8/2024, the care plan indicated Resident 75's goals of care were to maintain her body weight without avoidable change for 30 days. Staff interventions included encouraging and offering increased oral food intake to Resident 75. During a review of Resident 75's discontinued physician's order, dated 9/8/2024, the order indicated staff were to refer Resident 75 to the RD. During a review of Resident 75's monthly weights, dated 9/2024 to 11/2024, the weights indicated Resident 75 went from 256 lbs. on 9/1/2024 to 252 lbs. on 11/1/2024. During a review of Resident 75's IDT Care Conference Record, dated 11/5/2024, the record indicated the Dietary Supervisor (DS) attended. The record did not indicate the RD attended. The record did not indicate Resident 75 was on a weight loss plan, and indicated the DS determined Resident 75's weight was stable. During an interview on 11/12/2024 at 9:50 a.m., with Resident 75, Resident 75 stated that she did not eat a lot of the meals and felt hungry a lot of the time. Resident 75 stated that unidentified facility staff had told her that she had recently lost weight, and stated the weight loss was not planned or intentional. During an interview on 11/14/2024 at 11:14 a.m., with the DS, the DS stated the facility did not have salt alternatives available in the facility. The DS stated he started working at the facility in September 2024 and did not recall salt alternatives being available since he started. During an interview on 11/14/2024 at 11:43 a.m., with Resident 75, Resident 75 stated she used to receive salt alternatives with her meals and stated it had been over a year since she received any. Resident 75 stated she had brought up this concern to the dietary staff and was told salt alternatives were unavailable. During an interview on 11/14/2024 at 12:50 p.m., with the DS, the DS stated he ordered salt alternatives on 10/3/2024 from Vendor 1 and stated Vendor 1 did not have them available. The DS stated there was another vendor (Vendor 2) he could order the salt alternative from, but it was more expensive, so he did not attempt to order it through Vendor 2. The DS stated he should have attempted to order the salt alternative through Vendor 2. During an interview on 11/14/2024 at 12:57 p.m., with the DS, the DS stated salt alternatives can make food more palatable and more enticing for resident on a no added salt diet. The DS stated that decreased palatability could cause a resident to not want to eat the food and stated that if a resident did not want to eat, they were at risk for weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 8:48 a.m., with the RD, the RD stated her first assessment of Resident 75 was on 11/14/2024. The RD stated she did not receive any referrals to see Resident 75 prior to 11/14/2024. The RD stated Resident 75 was not on a planned weight loss regimen. During a concurrent interview and record review on 11/15/2024 at 11:01 a.m., with Medical Records (MR), Resident 75's Nutritional Assessments were reviewed. MR stated nutritional assessments performed by the RD would be documented in the EMR, and stated the only nutritional assessment conducted by the RD was done on 11/14/24. During a concurrent interview and record review, on 11/15/2024 at 11:14 AM, with Registered Nurse (RN) 2, Resident 75's monthly weights from 6/2024 to 11/2024 were reviewed. RN 2 stated Resident 75's monthly weights indicated Resident 75 had continuous weight loss from 6/2024 to 11/2024. RN 2 stated the facility should have addressed Resident 75's oral intake, and stated this could include addressing the palatability of the food. RN 2 stated that bland food could affect the resident's oral intake, and stated, If I put myself in their shoes, I wouldn't want to be eating bland food. RN 2 stated the facility should not wait until Resident 75 sustained significant or severe weight loss prior to providing intervention for weight loss. RN 2 stated that unaddressed weight loss can progress to significant or severe weight loss and stated that you want to prevent that problem. RN 2 stated Resident 75 was at risk for malnutrition. During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention, revised 1/2024, the P&P indicated care planning for weight loss was a multidisciplinary effort, and was supposed to include input from the RD. The P&P further indicated that the care plan included time frames and parameters for monitoring and reassessment. The P&P indicated the purpose was to prevent, monitor, and intervene for undesirable weight loss. During a review of the facility's job description titled Dietary Supervisor, undated, the job description did not indicate it was within the DS scope to determine if a resident's weight was stable. During a review of the facility's job description titled Registered Dietician, undated, the job description indicated it was the RD's responsibility to assess the nutritional status of residents per standards of practice. The job description indicated the RD was supposed to collaborate with the IDT and develop nutrition plans of care for the residents. The job description indicated the RD was supposed and monitor and evaluate effectiveness of nutritional interventions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services that were in accordance with facility policy for two of 11 sampled residents (Resident 32 and 15), when the facility did not display No Smoking/ Oxygen in Use signs on the outside of the doors of the resident room's or in the room where oxygen was in use for Resident 32 and 15. This deficient practice had the potential to cause fire hazards to all residents, families, visitors, staff, and residents' property, and result in serious harm and injury. Findings: a. During an observation on 11/12/2024 at 10:23 a.m., outside Resident 32's room, there was no No Smoking/ Oxygen in Use sign observed on the room entrance door. Resident 32 was observed using oxygen via a nasal cannula (NC, a device gave resident additional oxygen through nose) with an oxygen concentrator (a medical device that extracted oxygen from the air and delivered it to resident for breathing) at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. During an observation on 11/12/2024 at 3:19 p.m., outside Resident 32's room, there was no No Smoking/ Oxygen in Use sign observed on the room entrance door. Resident 32 was observed using oxygen via a NC with an oxygen concentrator at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. During an observation on 11/13/2024 at 10:49 a.m., outside Resident 32's room, there was no No Smoking/ Oxygen in Use sign observed on the room entrance door. Resident 32 was observed using oxygen via a NC with an oxygen concentrator at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. During a review of Resident 32's Admission Record, the admission record indicated Resident 32 was originally admitted to facility on 5/5/2014 and readmitted on [DATE]. Resident 32's diagnoses included congestive heart failure (CHF- a heart disorder which caused the heart to not pump the blood efficiently, sometimes resulting in leg swelling), pneumonia (an infection/inflammation in the lungs), epilepsy (a brain disease where nerve cells did not signal properly), generalized muscle weakness, and dementia (a progressive state of decline in mental abilities). During a review of Resident 32's History and Physical (H&P) dated 10/2/2024, the H&P indicated Resident 32 did not have the mental capacity to make decisions. During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 10/23/2024, the MDS indicated Resident 32's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated Resident 32 had impairment on the lower extremities and was dependent (helper did all the effort, resident did none of the effort to complete the activity) for self-care and mobility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's Order Summary report, as of 11/15/2024, the summary indicated an order, dated 11/12/2024, for oxygen 2 to 5 liter (L, a unit for measuring the volume of a liquid) to maintain oxygen saturation (a measure of how much oxygen is in the blood) at 91 percent (%) as needed. During a concurrent observation and interview on 11/13/2024 at 2:21 p.m. with Certified Nursing Assistant (CNA) 5, outside Resident 32's room, there was no No Smoking/ Oxygen in Use sign observed on the room entrance door. Resident 32 was observed using oxygen via a NC with an oxygen concentrator at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. CNA 5 stated Resident 32 should have a No Smoking/ Oxygen in Use sign so everyone would know there was oxygen inside the room. CNA 5 stated the purpose of the No Smoking/ Oxygen in Use sign was to make sure no one smoked, because it could explode and was a safety hazard. During a concurrent observation and interview on 11/13/2024 at 2:34 p.m. with Registered Nurse (RN) 1, outside Resident 32's room, there was no No Smoking/ Oxygen in Use sign observed on the room entrance door. Resident 32 was observed using oxygen via a NC with an oxygen concentrator at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. RN 1 stated Resident 32 should have a No Smoking/ Oxygen in Use sign for safety precautions. b. During an observation on 11/13/2024 at 12:28 p.m., outside Resident 15's room, there was no No Smoking/ Oxygen in Use sign observed on the room entrance door. Resident 15 was observed using oxygen via a NC with an oxygen concentrator at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. During a review of Resident 15's Admission Record, the admission record indicated Resident 15 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included sepsis (a life-threatening blood infection), pleural effusion (a buildup of fluid between the layers of tissue that lined the lungs and chest cavity), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), anemia (a condition where the body did not have enough healthy red blood cells), and dementia. During a review of Resident 15's H&P, dated 11/13/2024, the H&P indicated Resident 15's did not have the capacity to understand and make decisions. During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15's cognitive skills for daily decision making was intact. The MDS indicated Resident 15 was independent (residents completed the activity by themselves with no assistance from a helper) with self-care, indoor mobility, and functional cognition. The MDS indicated Resident 15 required partial assistance (helper did less than half the effort) in toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear, rolling left and right, sitting to lying, lying to sitting on the side of bed, sitting to standing, chair/bed-to-chair transfer, and toilet transfer. The MDS indicated Resident 15 had no impairment to the extremities and used cane/ crutch for mobility. During a review of Resident 15's Order Summary report, as of 11/13/2024, the summary indicated an order, dated 11/12/2024, for oxygen 2 to 5 L per minute via NC as needed for oxygen saturation less than 90%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/13/2024 at 2:30 p.m. with RN 1, outside Resident 15's room, there was no No Smoking/ Oxygen in Use sign observed on the room entrance door. Resident 15 was observed using oxygen via a NC with an oxygen concentrator at the bedside. There was no No Smoking/ Oxygen in Use sign observed in the room. RN 1 stated there should be No Smoking/ Oxygen in Use sign. RN 1 stated oxygen needed to be taken care of very carefully because of its fire hazard. RN 1 stated if there was a fire, there would be an explosion, and the resident would get burned and injured. RN 1 stated the resident and facility's properties would be burned from the fire. RN 1 stated everybody in the facility was responsible for ensuring there was a No Smoking/ Oxygen in Use sign when oxygen was in use. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised on 10/2010, the P&P indicated No Smoking/ Oxygen in Use sign was necessary for oxygen administration. The P&P indicated staff needed to place an Oxygen in Use sign on the outside of the room entrance door and in a designated place on or over the resident's bed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to ensure the accurate and complete documentation of the administration of Norco (medication used to treat moderate to severe pain) on the Medication Count Sheet for one of one sampled resident (Resident 104). This deficient practice had the potential to result in Resident 104 accidentally being administered an additional dose of Norco before the next dose was due, drug diversion (the act of health care providers stealing prescription medicine for their own use), and/or the potential for medication error to occur. Findings: During a review of Resident 104's Admission Record (Face Sheet), the admission record indicated Resident 104 was admitted to the facility on [DATE]. Resident 104's diagnosed included dementia (a progressive state of decline in mental abilities), chronic kidney disease (a long-term condition where the kidneys are damaged and can't filter blood properly), and contracture (a stiffening/shortening of any joint, that reduces the joint's range of motion) of the right and left knee. During a review of Resident 104's Minimum Data Set ([MDS], a resident assessment tool), dated 10/10/2024, the MDS indicated Resident 104's cognition (process of thinking) was severely impaired. The MDS indicated Resident 104 required maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 104 was dependent on staff's assistance with bathing and lower body dressing. The MDS indicated Resident 104 received pro re nata ([PRN], as needed) pain medication. The MDS indicated Resident 104 received opioid (used to treat moderate to severe medication) medication. During a review of Resident 104's History and Physical (H&P), dated 1/30/2024, the H&P indicated Resident 104 did not have the capacity to understand and make decisions. During a review of Resident 104's Order Summary Report, active orders as of 11/14/2024, the Order Summary Report indicated to give Norco 10-325 milligrams (mg, unit of measurement), by mouth, every six hours as needed for severe pain. (seven out of 10 pain scale). During a concurrent observation and interview on 11/13/2024 at 11:45 a.m., at Medication Cart 3, with Licensed Vocational Nurse (LVN) 2, Resident 104's bubble pack (a card used to store medications for the resident) for Norco was observed with 23 tablets left in the bubble pack. LVN 2 stated that there were 23 tablets of Norco left in the bubble pack. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/13/2024 at 11:47 a.m., with LVN 2, Resident 104's Medication Count Sheet, undated, was reviewed. The Medication Count Sheet indicated there were six doses (tablets) of Norco administered to Resident 104 with the last dose administered on 11/12/2024 at 9 a. m. The Medication Count Sheet indicated 24 doses should be left in the bubble pack. LVN 2 stated there was a discrepancy between Resident 104's Medication Count Sheet and bubble pack for Norco where the Medication Count Sheet indicated 24 doses of Norco should remain and the bubble pack for Norco only had 23 doses remaining. LVN 2 stated she had administered a dose of Norco to Resident 104 in the morning and she did not mark on the Medication Count Sheet after administering the dose to Resident 104. LVN 2 stated she was supposed to document on the Medication Count Sheet immediately after removing the tablet and administering to Resident 104. LVN 2 stated the purpose of the Medication Count Sheet was to keep the nurses accountable for the number of controlled medications in their medication cart to prevent drug diversion and to provide documentation that Resident 104 was administered the medication. During an interview on 11/14/2024 at 11:50 a.m., with the Director of Nursing (DON), the DON stated when a licensed nurse administered a controlled medication, they had to pour, pass, chart, which meant the licensed nurse would remove the dose from the bubble pack, administer the medication, and then chart on the required documents. The DON stated LVN 2 was responsible for documenting on the Medication Count Sheet after administering the dose of Norco to Resident 104. The DON stated if the medication remaining in the bubble pack and the documentation on the Medication Count Sheet did not match, there was a potential for drug diversion because if any controlled medication was missing, it could mean someone took it and did not give it to the resident. During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised 1/2024, the P&P indicated an individual resident controlled substance record must be kept and contain the name of the resident, the medication, number of doses on hand, date and time administered, and signature of the nurse who administered the dose.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure salt alternative seasoning (a product that can be used in place of salt [sodium chloride]) was available for and provided to one of 27 sampled residents (Resident 75), who was on a no added salt (NAS) diet. This deficient practice resulted in Resident 75's complaints of unappetizing and flavorless meals, a self-reported decreased intake of facility-provided meals, and placed Resident 75 at risk for unplanned and undesirable weight loss. This also placed Resident 75 at risk complications of her existing medical conditions, due to seeking out food that was not compliant with her prescribed diet. Findings: During a review of Resident 75's admission record, the admission record indicated Resident 75 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 75's admitting diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and stroke (loss of blood flow to a part of the brain), and hypertension (high blood pressure). During a review of Resident 75's History and Physical (H&P), dated 2/16/2024, the H&P indicated Resident 75 had the capacity to understand and make decisions. During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool), dated 8/10/2024, the MDS indicated Resident 75 had no cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions), and could eat independently. During a review of Resident 75's physician's order, dated 10/30/2023, the order indicated to provide Resident 75 a NAS diet. During a review of Resident 75's monthly weights, dated 6/2024 to 11/2024, the weights indicated Resident 75 had consistent weight loss every month from 6/2024 to 11/2024, and had lost a total of 14 pounds (lbs., a unit of weight measurement). During a review of Resident 75's care plan for altered nutrition, revised on 11/14/2024, the care plan indicated Resident 75 was non-compliant with her ordered diet, and consumed snacks from the vending machine and food purchased outside of the facility. Staff interventions included encouraging Resident 75 to comply with her diet, and to remind her of the risks associated with non-compliance. During an interview on 11/12/2024 at 9:50 a.m., with Resident 75, Resident 75 stated that she did not eat a lot of the meals and felt hungry a lot of the time. Resident 75 stated that unidentified facility staff told her that she recently lost weight, and stated the weight loss was not planned or intentional. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/2024 at 11:14 a.m., with the Dietary Supervisor (DS), the DS stated the facility did not have salt alternatives available in the facility. The DS stated he started working at the facility in September 2024 and did not recall salt alternatives being available since he started. During an interview on 11/14/2024 at 11:18 a.m., with the DS, the DS stated Resident 75 was provided with Tapatio brand hot sauce packets, and stated he was aware that the hot sauce packets were high in sodium. The DS stated Resident 75 would ask for them, so they were placed on her tray. During an interview on 11/14/2024 at 11:43 a.m., with Resident 75, Resident 75 stated she used to receive salt alternatives with her meals and stated it had been over a year since she received any. Resident 75 stated she had brought up this concern to the dietary staff and was told salt alternatives were unavailable. Resident 75 stated she received hot sauce packets with her meals and used them to add flavor to her food to make it more palatable. Resident 75 stated she did not know that the hot sauce packets were high in sodium, and stated she used the packets because salt alternatives were not available, and without the hot sauce, the food lacked flavor. During a concurrent interview and record review on 11/14/2024 at 12:00 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 75's physician's order dated 10/30/2023 was reviewed. LVN 1 stated Resident 75 was on a NAS diet and was not supposed to have additional sodium. LVN 1 stated he was responsible for checking the meal trays before they were delivered to the residents, and stated he was checking the trays for residents on a NAS diet for salt packets, but he did not check for condiments with high sodium content, including the Tapatio brand hot sauce packets. LVN 1 stated Resident 75 had heart failure and high blood pressure, and stated the added sodium could increase her risk for complications. LVN 1 stated the additional sodium from the hot sauce could increase Resident 75's blood pressure, fluid retention (excess fluid in the body), and could increase her risk for a heart attack or repeat stroke. During an interview on 11/14/2024 at 12:50 p.m., with the DS, the DS stated he ordered salt alternatives on 10/3/2024 from Vendor 1 and stated Vendor 1 did not have them available. The DS stated there was another vendor (Vendor 2) he could order the salt alternative from, but it was more expensive, so he did not attempt to order through Vendor 2. The DS stated he should have attempted to order the salt alternative through Vendor 2. During an interview on 11/14/2024 at 12:57 p.m., with the DS, the DS stated salt alternatives could make food more palatable and more enticing for residents on a no added salt diet. The DS stated that decreased palatability could cause a resident to not want to eat the food and stated that if a resident did not want to eat, they were at risk for weight loss. During an interview on 11/15/2024 at 8:48 a.m., with the facility's Registered Dietician (RD, a healthcare professional who specializes in nutrition and diet), the RD stated Resident 75 was not on a planned weight loss regimen. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 11/15/2024 at 11:14 AM, with Registered Nurse (RN) 2, Resident 75's monthly weights from 6/2024 to 11/2024 were reviewed. RN 2 stated Resident 75's monthly weights indicated Resident 75 had continuous weight loss from 6/2024 to 11/2024. RN 2 stated the facility should have addressed Resident 75's oral intake, and stated this could include addressing the palatability of the food. RN 2 stated that bland food could affect the resident's oral intake, and stated, If I put myself in their shoes, I wouldn't want to be eating bland food. During a review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention, revised 1/2024, the P&P indicated care planning for weight loss was a multidisciplinary effort, and was supposed to include input from the RD. The P&P further indicated that the care plan included time frames and parameters for monitoring and reassessment. The P&P indicated the purpose was to prevent, monitor, and intervene for undesirable weight loss. During a review of the facility's P&P titled Resident Food Preferences, revised 1/2024, the P&P indicated that if a resident was unhappy with their prescribed diet, the staff were supposed to create a care plan that the resident was satisfied with. The P&P further indicated staff documenting that a resident was refusing meals due to non-compliance was not appropriate.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure the physician was notified and orders were received prior to providing Tapatio brand hot sauce packets to one of 27 sampled residents (Resident 75), who was on a no added salt (NAS) diet. This deficient practice placed Resident 75 at risk complications of her existing medical conditions due to the high sodium content of the hot sauce packets. Findings: During a review of Resident 75's Admission Record, the admission record indicated Resident 75 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 75's admitting diagnoses included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and stroke (loss of blood flow to a part of the brain), and hypertension (high blood pressure). During a review of Resident 75's History and Physical (H&P), dated 2/16/2024, the H&P indicated Resident 75 had the capacity to understand and make decisions. During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool), dated 8/10/2024, the MDS indicated Resident 75 had no cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions), and could eat independently. During a review of Resident 75's physician orders, dated 10/30/2023, the orders indicated to provide Resident 75 a NAS diet. The order did not indicate Resident 75 was permitted to receive Tapatio brand hot sauce packets. During an observation on 11/12/2024 at 12:56 p.m., at Resident 75's bedside, observed Resident's 75 lunch tray on her bedside table. Resident 75 was served chicken enchiladas. There was a packet of Tapatio brand hot sauce on the tray, and her tray ticket indicated Resident 75 was on a NAS diet. During a review of the facility recipe titled, Recipe: Chicken Enchiladas, undated, the recipe did not indicate that hot sauce packets were permitted for resident on a NAS diet. During an interview on 11/14/2024 at 11:14 a.m., with the Dietary Supervisor (DS), the DS stated the facility did not have salt alternatives available in the facility. The DS stated he started working at the facility in September 2024 and did not recall salt alternatives being available since he started. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/14/2024 at 11:18 a.m., with the DS, Resident 75's physician orders dated 10/30/2023 and all of Resident 75's current care plans were reviewed. The DS stated Resident 75's physician orders and care plans did not indicate the resident was permitted to have the hot sauce packets while on a NAS diet. The DS stated Resident 75 was provided with Tapatio brand hot sauce packets, and stated he was aware the hot sauce packets were high in sodium. The DS stated Resident 75 was non-compliant with her diet because she asked for the packets, and staff provided the packets because it was Resident 75's preference. During an interview on 11/14/2024 at 11:43 a.m., with Resident 75, Resident 75 stated she received hot sauce packets with her meals and used them to add flavor to her food to make it more palatable. Resident 75 stated she did not know the hot sauce packets were high in sodium, and stated she used the packets because salt alternatives were not available, and without the hot sauce, the food lacked flavor. Resident 75 stated that if she had known the hot sauce packets were high in sodium or not in compliance with her diet, she would not use them or request them. During an observation on 11/14/2024 at 11:49 a.m., at Resident 75's bedside, a pile of six Tapatio brand hot sauce packets was observed on her bedside table. During a concurrent interview and record review on 11/14/2024 at 12:00 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 75's physician diet order dated 10/30/2023 and all of Resident 75's current care plans were reviewed. LVN 1 stated Resident 75 was on a NAS diet and was not supposed to have additional sodium. LVN 1 stated the physician orders and care plans did not indicate Resident 75's physician was notified of Resident 75 receiving or requesting Tapatio brand hot sauce packets, or that Resident 75 was allowed to receive the hot sauce packets. LVN 1 stated Resident 75 had heart failure and high blood pressure, and stated the added sodium could increase the resident's risk for complications. LVN 1 stated the additional sodium from the hot sauce could increase Resident 75's blood pressure, fluid retention (excess fluid in the body), and could increase her risk for a heart attack or repeat stroke. During an interview on 11/15/2024 at 8:48 a.m., with the Registered Dietician (RD, a healthcare professional who specializes in nutrition and diet), the RD stated she was first consulted to assess and talk with Resident 75 on 11/14/2024 due to her Tapatio brand hot sauce use. The RD stated she did not discuss the use of the hot sauce with Resident 75 prior to 11/14/2024. The RD stated that with Resident 75's existing medical conditions, sodium consumption that was not in compliance with her NAS diet could increase her risk for fluid accumulation in her body. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, revised 1/2024, the P&P indicated that if a resident was unhappy with their prescribed diet, the staff were supposed to create a care plan that the resident was satisfied with. The P&P further indicated staff documenting that a resident was refusing meals due to non-compliance was not appropriate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45009 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation practices in the kitchen when: 1. Dietary Aide (DA 1) did not change gloves between touching food items and nonfood items. 2. Dietary staff did not provide a closed container for the ice scooper. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals). Findings: During an observation on 11/15/2024 at 7:21 a.m., in the kitchen, DA 1 checked the menu slip on the food trays and provided juice, water, or milk on the food trays. DA 1 touched the doorknob of the kitchen door. DA 1 opened the kitchen door and left the kitchen and returned to touching the resident food trays and drinks with the same gloves. Nursing staff came to the kitchen door. DA 1 opened the kitchen door took the menu slip from the nursing staff and continued touching the residents' food tray and drinks without removing her gloves. During an interview on 11/15/202 at 7:48 a.m. with the Dietary Supervisor (DS), in the kitchen, the DS stated he taught his staff to change gloves when they touched a nonfood item. The DS stated the kitchen staff were not allowed to walk around the kitchen with gloves. The DS stated the kitchen staff were supposed to wear gloves when working with food and gloves must be removed before touching nonfood items. The DS stated kitchen staff should not touch things and go back to touch food with the same gloves for infection control purposes. The DS stated if kitchen staff did not remove their gloves residents could get a bacteria and have a food borne illness. The DS stated it was important to change gloves to promote safety for resident's health, and to prevent residents from getting sick when their health was already compromised. During an interview on 11/15/2024 at 8:05 a.m. with DA 1, in the kitchen, DA 1 stated she did not remove her gloves after she touched the kitchen door handle, after she received the menu slip from the nursing staff and after going out on the hallway. DA 1 stated she should have removed her gloves and washed her hands for infection control purposes. DA 1 stated the facility trained her to remove her gloves when touching nonfood items but she forgot to remove the gloves. DA 1 stated it was important to change the gloves to prevent residents from getting sick. During an observation on 11/15/2024 at 11:09 a.m., in the hallway, an ice scooper was observed uncovered exposed to air. The ice scooper was observed sitting on top of a zip lock bag. A resident seated on a wheelchair was observed passing by the table with the ice chest and scooper. The resident used the table to propel himself and touched the scooper. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/15/2024 at 1:09 p.m. with the DS, the DS stated the kitchen staff were responsible for providing a closed container for the ice scooper. The DS stated all scoopers should be covered up for infection control prevention. The DS stated if a scooper was uncovered, staff would not know if it was touched by a patient. The DS stated the scooper was placed in a zip lock bag and the zip lock bag should have been closed. The DS stated he usually had a container that held the ice scooper but it was unavailable. The DS stated it was not safe practice to have a scooper exposed to air and residents. During a review of the facility's Policy and Procedure (P&P) titled, Glove Use, undated, the P&P indicated the appropriate use of gloves was essential in preventing food borne illness. The P&P indicated gloves must be removed before beginning a different task.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure three out of three residents (Resident 39, 339 and 107) understood the arbitration (is a way of resolving a dispute without filing a lawsuit and going to court) agreement when Residents 39, 339, and 107 entered a binding contract (an agreement between two or more parties that creates certain obligations that must be adhered to by law) with the facility. This deficient practice resulted in Resident 39, 107, and 339 being unaware that his or her right to resolve a dispute in court was waived due to entering the binding arbitration agreement with the facility. Findings: a. During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was originally admitted to the facility on [DATE]. Resident 39's diagnoses included Stage IV pressure ulcer (a full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the right buttock, Stage IV pressure ulcers of the left and right heel, Stage IV pressure ulcer of the sacral region (buttocks), and adult failure to thrive (gradual decline in a person's ability to perform everyday activities, often due to multiple chronic medical conditions). During a review of Resident 39's Minimum Data Set ([MDS], a resident assessment tool), dated 10/13/2024, the MDS indicated Resident 39's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 39 required partial assistance when he ate, and was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 39's Arbitration Agreement, dated 10/11/2024, the Arbitration Agreement indicated Resident 39 signed and entered into the binding agreement. During an interview, on 11/12/2024 at 11:09 a.m., with Resident 39, Resident 39 stated he did not know what a binding arbitration was and stated that he did not recall anyone from the facility providing an explanation of what it was. b. During a review of Resident 107's Admission Record, the Admission Record indicated Resident 339 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident 107's diagnoses included cellulitis (a skin infection that causes swelling and redness) of the abdominal (stomach) wall, diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and end stage renal disease (irreversible kidney failure). During a review of Resident 107's MDS, dated [DATE], the MDS indicated Resident 107's cognitive skills for daily decision making was intact. The MDS indicated Resident 107 required substantial assistance (helper does more than half the effort) when toileting, showering, dressing, and performing personal hygiene. (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 107's Arbitration Agreement, dated 8/8/2024, the Arbitration Agreement indicated Resident 107 signed and entered into the binding agreement. During an interview on 11/13/2024 at 9:18 a.m., with Resident 107, Resident 107 stated she did not recall having the form explained to her. c. During a review of Resident 339's Admission Record, the Admission Record indicated Resident 339 was originally admitted to the facility on [DATE]. Resident 339's diagnoses included osteomyelitis (infection of the bone) of the left ankle and foot. During a review of Resident 339's MDS, dated [DATE], the MDS indicated Resident 339's cognitive skills for daily decision making was intact. The MDS indicated Resident 339 required supervision or partial moderate assistance (helper does half the effort) for performing ADLs. During a review of Resident 339's Arbitration Agreement, dated 10/31/2024, the Arbitration Agreement indicated Resident 339 signed and entered into the binding agreement. During an interview on 11/14/2024 at 12:00 p.m., with Resident 339, Resident 339 stated he recalled that there were four individuals that came to his room to go over paperwork and did not recall anyone explaining what a binding arbitration meant. Resident 339 stated that he was just told that the papers were just admission paperwork that needed to be signed and did not fully understand what the binding arbitration form entailed. During an interview on 11/14/2023 at 1 p.m., with the Admissions Coordinator (AC), the AC stated she was responsible for ensuring the admission paperwork was signed and explained to the resident or the responsible party. The AC stated that if the resident was alert, she would explain what a binding arbitration meant and would answer any questions the resident may have. The AC stated the residents have the right to understand, enter, and/or decline the facility's binding arbitration agreement. During an interview on 11/14/2024 at 3:59 p.m., with the Administrator (ADM), the ADM stated that it was important that all residents understood and were given a thorough explanation of what a binding arbitration agreement entails, especially because the facility's arbitration contained difficult and complex terms that were not easy to understand. The ADM stated that it was the resident's right to enter or decline the facility's binding arbitration with full understanding.

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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** 47286 Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP, a resident-centered and activity-based approach for preventing infection spread) for four of 27 sampled residents (Residents 72, 24, 62, and 39). This deficient practice increased the potential for spread of multidrug-resistant organisms (MDROs, a type of bacteria that has become resistant to multiple antibiotics and other antimicrobial agents) among vulnerable facility residents. Findings: 1. During a review of Resident 72's Admission Record, the Admission Record indicated Resident 72 was admitted to the facility on [DATE]. Resident 72's admitting diagnoses included generalized muscle weakness, dementia (a progressive state of decline in mental abilities), and cancer to the colon (the longest part of the large intestine). During a review of Resident 72's History and Physical (H&P), dated 6/24/2024, the H&P indicated Resident 72 had fluctuating capacity to understand and make decisions. During a review of Resident 72's Minimum Data Set (MDS, a resident assessment tool), dated 9/10/2024, the MDS indicated Resident 72 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 72 was dependent on facility staff for activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility while in and out of bed. The MDS indicated Resident 72 had an unhealed Stage IV pressure ulcer (the most severe type of pressure ulcer [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence], extending through to the muscle, tendon, or bone) During a review of Resident 72's active physician orders, the orders indicated there were no physician orders for EBP. During an observation on 11/13/2024 at 9:42 a.m., outside of Resident 72's room, there was signage observed indicating Resident 72's roommate required EBP. The signage did not indicate Resident 72 required EBP. During a concurrent observation and interview, on 11/13/2024 at 11:16 a.m., with Licensed Vocational Nurse (LVN) 1, the signage outside of Resident 72's room was observed. LVN 1 stated the signage did not indicate Resident 72 was on EBP. During an observation on 11/13/2024 at 2:52 p.m., outside of Resident 72's room, there was signage observed indicating Resident 72's roommate required EBP. The signage did not indicate Resident 72 required EBP. (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 observation on 11/14/2024 at 8:27 a.m., outside of Resident 72's room, there was signage observed indicating Resident 72's roommate required EBP. The signage did not indicate Resident 72 required EBP. During an observation on 11/14/2024 at 8:48 a.m., outside of Resident 72's room, there was signage indicating Resident 72's roommate required EBP. The signage did not indicate Resident 72 required EBP. 2. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 24's admitting diagnoses included a pressure ulcer to the tailbone area and quadriplegia (inability to from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 did not have cognitive impairments and was dependent on staff for activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility. The MDS indicated Resident 24 had an unhealed Stage III pressure ulcer (a pressure ulcer that involves full thickness tissue loss, but does not expose bone, tendon, or muscle). During a review of Resident 24's active physician orders, the physician orders indicated there were no physician orders for EBP. During an observation on 11/12/2024 at 2:53 p.m., outside of Resident 24's room, there was no signage indicating Resident 24 required EBP. There was no personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) outside of the room for staff to use. During an observation on 11/13/24 at 9:11 a.m., outside of Resident 24's room, there was no signage observed indicating Resident 24 required EBP. There was no PPE outside of the room for staff to use. During an observation on 11/13/2024 at 2:50 p.m., outside of Resident 24's room, there was no signage observed indicating Resident 24 required EBP. There was no PPE outside of the room for staff to use. During an observation on 11/13/2024 at 3:48 p.m., outside of Resident 24's room, there was no signage observed indicating Resident 24 required EBP. There was no PPE outside of the room for staff to use. During an observation on 11/14/24 at 8:24 a.m., in the doorway of Resident 24's room, there was no signage observed indicating Resident 24 required EBP. There was no PPE outside of the room for staff to use. At Resident 24's bedside, a phlebotomist (a medical professional who draws blood from patients) was observed wearing gloves and a mask while drawing blood from Resident 24's right arm. The phlebotomist was not wearing a protective gown. (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 on 11/14/2024 at 8:33 a.m., outside of Resident 24's room, with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 24 did not have signage observed indicating he required EBP. CNA 1 stated the signage was how staff knew which precautions and PPE were required, and stated that because there was no signage posted, Resident 24 did not require EBP. 3 During a review of Resident 62's Admission Record, the Admission Record indicated Resident 62 was admitted to the facility on [DATE], and his admitting diagnoses included sepsis (a life-threatening complication of an infection) and stage 4 pressure ulcers to the right and left heel. During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62 did not have cognitive impairment. The MDS indicated Resident 62 required substantial to maximal assistance from staff for toileting and showering and required partial to moderate assistance from staff for personal hygiene (combing hair, shaving, washing hands/face). The MDS indicated Resident 62 had two unhealed Stage IV pressure ulcers. During a review of Resident 62's active physician orders, the physician orders indicated there were no physician orders for EBP. During an observation on 11/12/2024 at 10:35 a.m., outside of Resident 62's room, there was signage observed indicating Resident 62's roommate required EBP. The signage did not indicate Resident 62 required EBP. During a concurrent observation and interview on 11/12/2024 at 10:53 a.m., with Resident 62, observed gauze dressings to both of Resident 62's lower extremities. Resident 62 stated he had wounds on his feet. During an observation on 11/13/2024 at 3:49 p.m., outside of Resident 62's room, there was signage observed indicating Resident 62's roommate required EBP. The signage did not indicate Resident 62 required EBP. During an observation on 11/14/2024 at 8:31 a.m., outside of Resident 62's room, there was signage observed indicating Resident 62's roommate required EBP. The signage did not indicate Resident 62 required EBP. 4. During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was admitted to the facility on [DATE], and his admitting diagnoses included osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the left ankle and foot, sepsis, Stage IV pressure ulcers to the right buttock, tailbone area, right heel, and left heel. During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 did not have cognitive impairments. The MDS indicated Resident 39 was dependent on staff for toileting, showering, personal hygiene, and getting dressed, and was dependent on staff for mobility. The MDS indicated Resident 39 had seven unhealed Stage IV pressure ulcers and diabetic ulcers. During a review of Resident 39's active physician orders, there were no physician orders for EBP. (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 observation on 11/13/2024 at 3:51 p.m., outside of Resident 39's room, there was signage observed indicating Resident 39's roommate required EBP. The signage did not indicate Resident 39 required EBP. During an observation on 11/14/2024 at 8:24 a.m., outside of Resident 39's room, there was signage observed indicating Resident 39's roommate required EBP. The signage did not indicate Resident 39 required EBP. During a concurrent interview and record review, on 11/14/24 at 8:59 a.m., with the Infection Preventionist Nurse (IPN), the facility matrix, dated 11/11/2024, the Centers for Disease Control (CDC) guidance for EBP dated 6/28/2024, and the facility policy and procedure (P&P) titled, Enhanced Standard Precautions, dated 5/2024, were reviewed. The IPN stated the facility used the CDC guidance for EBP and stated the CDC guidance indicated that all residents with wounds required staff to implement EBP. The IPN stated the facility P&P indicated all wounds required staff to implement EBP. The IPN stated the facility matrix indicated Residents 72, 24, 62, and 39 all had wounds requiring staff to implement EBP. The IPN stated that there was risk for spread of MDROs in the facility if EBP was required but not being implemented. During a review of the CDC guidance titled, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/2024, the guidance indicated that all residents with wounds met the criteria for Enhanced Barrier Precautions, and indicated these wounds included, but were not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers. During a review of the facility's P&P titled, Enhanced Standard Precautions, dated 5/2024, the P&P indicated that residents who were high risk for MDRO transmission, and required EBP, included residents with wounds or unhealed pressure ulcers. The P&P indicated staff were supposed to wear protective gowns and gloves (PPE) when performing any activity where close contact with the resident was expected, including during morning and evening care, and when giving medical treatment.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure two of 50 bedrooms accommodated no more than four residents in each room. This deficient practice had the potential to lead to inadequate space to care for residents, and store residents' belongings and equipment. Findings: During a review of the facility's Census, dated 11/12/2024, the Census indicated five residents occupied room [ROOM NUMBER] (12A, 12B, 12C, 12C, 12D, 12E) and four residents occupied room [ROOM NUMBER] (32A, 32B, 32C, 32D, 32E). During a review of the facility's Room Variance Waiver letter, dated 11/12/2024, submitted by the Administrator (ADM), the letter indicated rooms [ROOM NUMBERS] had five beds each. The letter indicated the rooms were utilized for higher acuity residents requiring more care. room [ROOM NUMBER] was located one foot away from the fire exit door when measured from the doorway to the exit. The letter indicated room [ROOM NUMBER] was located five feet away from a fire exit door when measured from the doorway to the exit. The letter indicated the waiver was in accordance with the special needs of the residents and does not adversely affect the health and safety of the residents or impede the ability of any resident from attaining his or her highest practicable well-being. During a concurrent facility tour observation and interview on 11/14/2024 at 3:59 p.m., with the ADM, observed five residents occupied room [ROOM NUMBER], and four residents occupied room [ROOM NUMBER]. The residents were able to move in and out of the rooms, and there was space for the residents' beds, side tables, and residents' care equipment. The ADM stated there was a risk of decreased space for the residents, staff, and equipment, and a risk that the residents would feel uncomfortable. The ADM stated the room waiver was submitted for rooms [ROOM NUMBERS] because they were occupied by more than four residents.

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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** 47858 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft.) per resident in multiple resident bedrooms for 31 of 50 residents' rooms. This deficient practice had the potential to result in inadequate space for daily living, and for facility staff to care for the residents. Findings: During a review of the facility's Census, dated 11/12/2024, the Census indicated four rooms (Rooms 1, 2, 3, and 4) had the capacity for two residents in each room. The Census indicated 27 rooms (Rooms 5, 19, 20, 22, 23, 23, 24, 25, 26, 27, 28, 29, 30, 34, 35, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, and 49) had the capacity for three residents in each room. During a review of the facility's Room Variance Waiver letter, dated 11/12/2024, the letter indicated 31 rooms did not meet the 80 sq. ft. requirement by federal regulations. The letter indicated the waiver was in accordance with the special needs of the residents and does not adversely affect the health and safety of the residents or impede the ability of any resident from attaining his or her highest practicable well-being. The following rooms provided less than 80 sq. ft. per resident: room [ROOM NUMBER], capacity 2, measured 157.98 sq. ft. room [ROOM NUMBER], capacity 2, measured 142.30 sq. ft. room [ROOM NUMBER], capacity 2, measured 156.65 sq. ft. room [ROOM NUMBER], capacity 2, measured 153.91 sq. ft. room [ROOM NUMBER], capacity 3, measured 223.26 sq. ft. room [ROOM NUMBER], capacity 3, measured 203.95 sq. ft. room [ROOM NUMBER], capacity 3, measured 221.40 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 259.48 sq. ft. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER], capacity 3, measured 197.96 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 219.52 sq. ft. room [ROOM NUMBER], capacity 3, measured 214.50 sq. ft. room [ROOM NUMBER], capacity 3, measured 215.60 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 218.40 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 214.50 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 216.45 sq. ft. room [ROOM NUMBER], capacity 3, measured 215.60 sq. ft. room [ROOM NUMBER], capacity 3, measured 217.56 sq. ft. room [ROOM NUMBER], capacity 3, measured 235.88 sq. ft. During a concurrent facility tour observation and interview on 11/14/2024 at 3:59 p.m., with the ADM, there was space noted for residents in 31 rooms (Rooms 1, 2, 3, 4, 5, 19, 20, 22, 23, 23, 24, 25, 26, 27, 28, 29, 30, 34, 35, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, and 49) to be able to move in and out of the rooms, and there was space for the residents' beds, side tables, and residents' care equipment. The ADM stated there was a risk of decreased space for the residents, staff, and equipment, and a risk that the residents would feel uncomfortable. The ADM stated the room waiver was submitted for 31 rooms because these rooms measured less than 80 sq. ft. per resident capacity of the rooms.