STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Royal Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 909 W. Santa Anita Ave San Gabriel, CA 91776	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review, the facility failed to treat resident with respect and dignity, and maintain privacy for five (5) of 23 sampled residents (Residents 47, 59, 73, 75, and 25) in accordance with the facility policy by failing to ensure: 1. Resident 47 was fed at eye level. 2. Resident 59's curtain or door was closed when staff changed the resident. 3. Resident 73's curtain or door was closed when staff changed the resident. 4. Failing to address Resident 25 by her name. 5. Resident 75 was fed at eye level. These deficient practices had the potential to negatively affect Residents 47, 59, 73, 75, and 25's self-worth, self-esteem, and psychosocial well-being. Findings: 1. During a record review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was admitted to the facility on [DATE], with diagnoses of metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), schizoaffective disorders (a mental illness that causes loss of contact with reality), and major depressive disorders (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a record review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 10/26/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 47 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for eating. During an observation on 11/18/2024 at 12:47 PM in Resident 47's room, Certified Nursing Assistant (CNA 9) was standing and reaching over the bedside table to feed Resident 47 in bed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA 9, CNA 9 stated CNA 9 was in a standing position while feeding Resident 47. During an interview on 11/21/2024 at 8:28 AM with Registered Nurse Supervisor (RNS 1), RNS 1 stated staff were supposed to sit in a chair when feeding a resident while in bed. RNS 1 stated sitting while feeding the resident was respectful and showed the resident staff were not rushed to feed the resident. During a review of Resident 47's care plan, dated 10/21/2024, the care plan indicated Resident 47 had self-care deficits related to cognitive deficits, communication deficits, muscular weakness, poor safety awareness, and weakness. The care plan interventions for staff were to assist with activities of daily living as needed, maintain resident's privacy, and respect their rights, and provide with adequate hydration and nutrition. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated when assisting with care, residents are provided with a dignified dining experience. 2. During a record review of Resident 59's Admission Record, the Admission Record indicated Resident 59 was admitted to the facility on [DATE], with diagnoses of dementia (progressive brain disorder that slowly destroys memory and thinking skills), history of falling, and altered mental status (AMS, a change in the resident's average mental function). During a record review of Resident 59's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 59 was dependent for shower/bath self. The MDS indicated Resident 59 was dependent for shower/bathe self. The MDS also indicated Resident 59 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, upper and lower body dressing, personal hygiene (ability to maintain hygiene, including combing hair, shaving, applying makeup, washing/drying face, and hands), sit to lying, sit to stand, and toilet transfer. During a review of Resident 59's care plan, dated 12/10/2023, the care plan indicated Resident 59 had impaired cognitive function/impaired thought processes. The care plan interventions were for staff to promote dignity, converse with resident and ensure privacy when providing care, and to provide a homelike environment. During an observation on 11/19/2024 at 10:25 AM in Resident 59's room, CNA 10 was changing Resident 59. Resident 59 was sitting on a shower chair with bottom part of her body exposed while the curtain and door were opened. During an interview on 11/19/2024 at 10:34 AM with CNA 10, CNA 10 stated Resident 59 was just brought back from taking a shower. CNA 10 stated she changed Resident 59 with the curtain and door open. CNA 10 stated she should have closed the curtain or the door to ensure the resident's privacy was protected. (continued on next page)

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F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

3. During a record review of Resident 73's Admission Record, the Admission Record indicated Resident 73 was admitted to the facility on [DATE], with diagnoses of angina pectoris (chest pain or discomfort that occurs when part of the heart muscle does not get enough oxygen-rich blood), emphysema (long-term lung condition that causes shortness of breath), and chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs).

During a record review of Resident 73's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 73 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathe self, upper and lower body dressing, sit to lying, sit to stand, and chair/bed-to-chair transfer.

During an observation on 11/18/2024 at 11:02 AM in Resident 73's room, CNA 11 was observed changing Resident 73's clothes with the curtain and door opened.

During an interview on 11/18/2024 at 11:06 AM with CNA 11, CNA 11 stated she just changed Resident 73's briefs (protective underwear to prevent leakage), cleaned his bottom, and transferred him to the wheelchair. CNA 11 stated she was aware the curtain and door were opened when changing Resident 73. CNA 11 stated she should have closed the curtain and door per facility's policy was to maintain the resident's privacy.

During an interview on 11/21/2024 at 8:25 AM with RNS 1, RNS 1 stated staff should either close the curtain or the door when changing residents to ensure their privacy. RNS 1 stated when resident curtains or door is not closed, there were passersby who could see the residents being changed. RNS 1 also stated even if the resident was confused, staff still needed to respect the individual as a human being and ensure privacy.

During a review of Resident 73's care plan, dated 8/22/2024, the care plan indicated Resident 73 had self-care deficits related to cognitive deficits, communication deficits, muscular weakness, poor safety awareness, unsteady gait, and weakness. The care plan interventions for staff were to assist with activities of daily living as needed, encourage resident to do as much as possible to increase independence, and maintain resident's privacy and respect their rights.

During a review of the facility's P&P titled, Dignity, revised 2/2021, the P&P indicated staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

46919

4. During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included epilepsy (a brain disorder that causes recurring , unprovoked episodes of abnormal electrical activity in the brain), personal history of transient ischemic attack (TIA- a brief stroke that occurs when blood flow to the brain is temporarily blocked) and cerebral infarction (a condition that occurs when blood flow to the brain is disrupted causing brain cells to die) without residual effects, and hypotension (low blood pressure).

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 25 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, personal hygiene, and upper and lower body dressing. Resident 25 required supervision or touching assistance with sit to lying, sit to stand, and toilet transfer. During a review of Resident 25's Care Plan, dated 8/12/2020, the care plan indicated Resident 25 had impaired cognitive function/impaired thought processes, short term memory loss, long term memory loss related to (r/t) cerebral hemorrhage (when a blood vessel in the brain ruptures and bleeds between the brain and skull) due to (d/t) ruptured aneurysm (a bulge or ballooning in the wall of a blood vessel) status post (s/p) coil embolization (the use of a metal coil to block blood flow in a blood vessel), dementia (a progressive state of decline in mental abilities). Resident 25 was alert with episode of confusion, verbally responsive, able to converse. Resident 25's care plan intervention indicated to use communication techniques to facilitate interaction: use resident's preferred name and promote dignity. During a review of Resident 25's Care Plan, dated 8/12/2020, the care plan indicated Resident 25's preference to be called by her name. Resident 25's care plan intervention indicated to frequently call Resident 25 by her name to get attention by making eye contact for a few seconds or minutes. During an observation in Resident 25's room and interview with Resident 25, on 11/18/2024, at 8:56 AM, Resident 25 was sitting on her bed looking for her call light. Certified Nursing Assistant 8 (CNA 8) entered the room and called Resident 25 Mama while helping Resident 25. Resident 25 told CNA 8 Don't call me Mama. Resident 25 informed CNA 8 to call Resident 25 by her name. During a follow up interview with CNA 8, on 11/18/2024, at 12:44 PM, CNA 8 stated she forgot that Resident 25 does not like to be called Mama. CNA 8 stated Resident 25 always gets upset when she is not called by her name. During an interview with Resident 25, on 11/18/2024, at 12:58 PM, Resident 25 stated facility staff always call her Mama even after she told the staff to call her by her name. Resident 25 stated this has been happening since she was admitted to the facility. Resident 25 stated, Do I look like a Mama to you? Resident 25 stated she felt irritated, insulted, and did not like not being called by her name. During an interview with CNA 1, on 11/19/2024, at 3:05 PM, CNA 1 stated facility staff should ask residents what name they prefer to be called and address residents by that preferred name. CNA 1 stated it was disrespectful to call Resident 25 Mama if she preferred to be called by her name. During an interview with RNS 1 on 11/21/2024, at 3:59 PM, RNS 1 stated facility staff should respect the wishes of the residents to be called by their preferred names. RNS 1 stated facility staff should treat residents with dignity. During a review of the facility's P&P titled, Dignity, revised on 2/2021, the P&P indicated the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Each Resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. -Residents are treated with dignity and respect at all times. -The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. -Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnoses, or care needs. 48143 5. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted to the facility on [DATE], with diagnoses that included end stage renal disease (a permanent condition that occurs when the kidneys are no longer able to function and require dialysis or a kidney transplant to survive), chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood properly), unspecified intellectual disabilities (a diagnosis given when it's difficult or impossible to assess the degree of intellectual disability in someone over the age of five [5]), and dependence on renal dialysis [(a state of requiring dialysis, (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) to maintain life] . During a review of the MDS, dated [DATE], indicated Resident 75 had severely impaired (never/ rarely made decisions) for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 75 is dependent, (helper does all of the effort) with the eating, oral, toilet, personal hygiene, change of position, and transfer. During a concurrent observation and interview on 11/19/2024 at 5:07 PM in Resident 75's room, observed CNA6 feeding Resident 75 by standing up next to Resident 75's left side of the bed. CNA6 stated she feeds all her residents standing up as there is no chair for her to sit down to feed the residents. During a review of the facility's P&P titled, Dignity, dated 2/2021, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are always treated with dignity and respect. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to treat cognitively impaired residents with dignity and sensitivity. During a review of the facility's P&P titled, Dignity, revised 2/2021, the P&P indicated when assisting with care, residents are provided with a dignified dining experience.

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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** 45456 Based on observation, interview, and record review, the facility failed to fully inform the resident in advance, of the risks and benefits of proposed care for two of 23 sampled residents (Resident 185 and 62) in accordance with the facility policy when: 1. Resident 185's Admission Consent Forms (consent for treatment, disclose medical record, and photograph) were not completed and signed upon admission on 11/12/2024. 2. An informed consent was not obtained prior to Resident 62's use of psychoactive medication (drug that changes brain function and results in altercations in perception, mood, consciousness or behavior) Seroquel (an antipsychotic drug to treat certain mental conditions). This deficient practice had the potential for Residents 185 and 62 not to be able to exercise their right to choose their treatment plan. Findings: 1. During a review of Resident185's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), adult failure to thrive (FTT, a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), syncope (fainting or passing out), and fall (unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force). During a review of Resident 185's History and Physical (H&P), dated on 11/13/2024, Resident 185 does not have the capacity to understand and make decisions. During a review of Resident 185's Skilled Nurses' Notes, dated 11/13/2024, the nurses' notes indicated Resident 185 was totally dependent (helper does all of the effort, resident does none of the effort to complete the activity) with bed mobility, transfer, locomotion, and toileting. During a concurrent interview with Registered Nurse Supervisor 1 (RNS 1) and review of Resident 185's Admission Consent Form on 11/19/2024 at 4:04 PM, the Admission Consent Form had no date and was not signed by the resident, responsible party, and facility representative. RNS 1 stated, the Admission Consent Form contains consent for treatment, disclose medical record and photograph and should have been completed during admission. RNS1 stated if the resident came in later that evening, the staff should have completed the form the following day. RNS 1 stated the facility staff should have called the family member. RNS 1 added, The Admission Consent form is important because it is a legal document. It contains Health Insurance Portability and Accountability Act (HIPAA, is a federal law that protects the privacy and security of health information) and disclosing of medical records. It means the resident/ responsible party was giving us consent to take care of the resident. During an interview with the RNS 1 on 11/19/2024 at 4:06 PM, RNS 1 stated, Not completing the Admission Consent Form meant, the resident did not give consent to treatment, disclose medical records, and take the resident's photograph. (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, Resident Rights, dated on 2/2021, P&P indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the Resident's right to be informed of, and participate, in his or her care planning and treatment; choose an attending physician and participate in decision making regarding his or her care. 44636 2. During a review of the Resident 62's Admission Record, the Admission Record indicated Resident 62 was admitted to the facility on [DATE], with diagnoses of psychosis (a mental disorder characterized by a disconnection from reality) and dementia (progressive brain disorder that slowly destroys memory and thinking skills). During a record review of Resident 62's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 9/26/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 62 had a psychiatric/mood disorder. The MDS also indicated Resident 62 did not have any mood and behaviors. During a review of Resident 62's Physician Order Summary Report, dated 5/15/2024, the Physician Order Summary Report indicated the following order: - Quetiapine Fumarate (Seroquel, antipsychotic drug used to treat certain mental conditions) oral tablet 25 mg: Give one tablet by mouth at bedtime for psychosis. During a concurrent review of Resident 62's medical record and interview with RNS 1 on 11/21/2024 at 4:23 PM, RNS 1 stated Resident 62 did not and should have an informed consent prior to use of Seroquel. RNS 1 stated the psychotropic medication had a lot of side effects and would help control the resident's behavior, so the licensed nurse needed to obtain an informed consent from the resident or responsible party and signed by the physician in order to administer the medication to Resident 62. During a review of the facility's Policy and Procedure (P&P) titled, Antipsychotic Medication Use, revised 8/2022, the P&P indicated residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose, and potential adverse consequences of antipsychotic medication use.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to follow its policy on Self-administration of Medications for one (1) of 23 sampled residents (Resident 20) by failing to obtain a physician order and conducting an assessment to determine if the resident was capable to self-administer medications. This deficient practice had the potential to result in unsafe medication administration, omission, and/or duplication of medications, which can result to complications. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included calculus of gallbladder with acute cholecystitis without obstruction (a condition where gallstones build up in the gallbladder and cause inflammation), lack of coordination, and unspecified glaucoma (a chronic eye disease that occurs when fluid builds up in the eye damaging the optic nerve and causing increased pressure in the eyeball). During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool), dated 8/21/2024, the MDS indicated Resident 20 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 20 required setup of clean-up assistance with eating. Resident 20 was dependent (helper does all of the effort) with toileting hygiene, upper/lower body dressing, and personal hygiene. During a concurrent observation in Resident 20's room and interview with Resident 20 on 11/18/2024, at 3:28 PM, 1 bottle of Cod Liver Oil (a vitamin A and D supplement) and 1 bottle of Halibut Liver Oil (a vitamin A and D supplement) were noted on top of Resident 20's bedside table. Resident 20 stated she owned both medications and takes them at night or when she is hungry. Resident 20 stated she wanted to take the medications herself. Resident 20 stated her family brought the medications to the facility. Resident 20 stated the medications were not prescribed by her physician. During a concurrent observation in Resident 20's room and interview with Registered Nurse Supervisor 1 (RNS 1), on 11/21/2024, at 1:49 PM, RNS 1 confirmed Resident 20 had a Cod Liver Oil bottle and a Halibut Liver Oil bottle on top of her bedside table. RNS 1 stated these medications were not prescribed by Resident 20's physician. RNS 1 stated all medications taken by residents should be prescribed by the physician. RNS 1 stated licensed nurses need to inform and get an order from the physician about medications brought by family members. RNS stated facility staff should have immediately addressed the medications kept at Resident 20's bedside table to the licensed nurse and Resident 20's physician. RNS 1 stated Resident 20 should not self-administer unprescribed medications brought by her family. RNS 1 stated medications should be administered by the Charge Nurse (CN). RNS 1 stated unprescribed medications had the potential to cause toxicity, overdose, or can be taken by another resident. RNS 1 stated she was unsure regarding the facility's policy and procedure (P&P) regarding resident's self-administration of medications. RNS 1 stated the facility's P&P on self-administration of medications should be followed. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of Resident 20's clinical record and interview with Medical Records Director 1 (MDR 1), on 11/21/2024, at 4:08 PM, MDR 1 stated Resident 20 did not have an IDT assessment form to self-administer medication. During a review of the facility's P&P, titled, Self-Administration of Medications, revised on 2/2021, the P&P indicated the following: - Residents have the right to self-administer medications if the interdisciplinary team (IDT- a group of healthcare professionals who work together to help people receive the care they need) had determined that it is clinically appropriate and safe for the residents to do so. - As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. - Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. - Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility's P&P titled, Administering Medications, revised on 4/2019, the P&P indicated, Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to ensure the call light (device used by residents to call staff) was in reach for one (1) of 23 sampled residents (Resident 185) in accordance with the facility policy and procedure for Residents'Call System. This failure had the potential for Resident 185 to not be able to call for assistance, which could result in untimely delivery of care and services. Findings: During a review of Resident 185's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included adult failure to thrive (FTT, a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), benign prostatic hyperplasia (BPH, also known as an enlarged prostate, is a noncancerous condition in which the prostate gland becomes larger than normal), syncope (fainting or passing out), and fall (unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force). During a review of Resident 185's History and Physical (H&P), dated on 11/13/2024, Resident 185 does not have the capacity to understand and make decisions. During a review of Resident 185's Skilled Nurses Notes dated 11/13/2024, the nurses' notes indicated Resident 185 was total dependent (helper does all of the effort, resident does none of the effort to complete the activity) in bed mobility, transfer, locomotion, and toileting. During a review of Resident 185's care plan dated 11/12/2024, indicated Resident 185 was at risk for further decline in cognition (ability to think and make decision). Resident 185 has cognitive and communication deficit as manifested by diagnosis of dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), short term memory problem, failure to thrive, and history of syncope and collapse. The care plan indicated intervention to keep call light within reach. During a concurrent observation in Resident 185's room and interview with Resident 185 on 11/18/2024 at 9:26 AM, Resident 185 stated he did not know where his call light is. Observed Resident 185's call light placed under the draw sheet and not within Resident 185's reach. Resident 185 stated he knows how to use the call light, but he cannot find it. Resident 185 wanted some hot tea, or hot water that is why he needs to use the call light to ask for facility's staff's assistance. During a concurrent observation in Resident 185's room and interview with Licensed Vocational Nurse 2 (LVN 2) on 11/18/2024 at 9:28 AM, LVN 2 came inside Resident 185's room and saw Resident 185's call light was placed under the resident's sheets. LVN 2 stated, call light should always be placed within Residents 185' reach so he can call for assistance when he needs help. (continued on next page)

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F 0558 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, Call System, Residents revised on 9/2022, the P&P indicated each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on interview and record review, the facility failed to inform and provide a written information for one (1) of four (4) sampled residents (Resident 21) on the option to formulate an advance directive (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the resident is incapacitated [clinical state in which a resident is unable to participate in a meaningful way in medical decisions]) as indicated on the facility's policy. This deficient practice violated the resident's and/or the representative's right to be fully informed of the option to formulate their advance directives and had the potential to unwanted treatment with the resident's wishes regarding health care. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body needs for blood and oxygen), chronic kidney disease (is a condition in which the kidneys are damaged and cannot filter blood as well as they should), and hypertensive heart disease (a long-term condition that develops over many years in people who have high blood pressure) During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool) dated 8/9/2024, the MDS indicated Resident 21 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 21 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on and taking off footwear, sit to stand, chair/bed -to chair transfer, toilet transfer, sit to lying, lying to sitting on side of the bed, chair/bed-to chair transfer and tub/shower transfer. During a record review of Resident 21's medical record on 11/19/2024 at 9:51 AM, there was no advance directive or advance directive acknowledgement form to indicate the resident or resident representative was made aware of the resident's right to formulate an advance directive. During a concurrent review of Resident 21's medical record and interview with Social Services Director (SSD) on 11/19/2024 at 3:40 PM, SSD stated, she cannot find neither the advance directive nor the advance directive acknowledgement form to indicate the resident or resident representative was made aware of the resident's right to formulate an advance directive. During an interview with SSD on 11/19/2024 at 3:45 PM, SSD stated it was important to have the Advance Directives in the Resident's chart, so the staff knows what to do, what to follow regarding the medical decision, and know who the decision maker is. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure titled, Advance Directives, dated 2001, P&P indicated the resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.

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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** 44636 Based on observation, interview, and record review, the facility staff failed to provide privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative) of the resident's medical records for one of 23 sampled residents (Resident 71). This deficient practice had the potential to expose Resident 71's records to others and violated the resident's right for privacy and confidentiality. Findings: During a record review of Resident 71's Admission Record, the Admission Record indicated Resident 71 was admitted to the facility on [DATE], with diagnoses of nontraumatic intracerebral hemorrhage (bleeding into the substance of the brain in the absence of trauma or surgery), encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), and acute kidney failure (when the kidneys suddenly become unable to filter waste products from the body). During a record review of Resident 71's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 9/19/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 71 was dependent (helper does all the effort, resident does not of the effort to complete the activity) for toileting hygiene and required substantial/maximal assistance (helper does more than half the effort) for upper and lower body dressing. During an observation in the hallway on 11/18/2024 at 10:49 AM, Resident 71's Physician's Order Details were left exposed and unattended on top of medication cart 1. The Physician's Order Details contained Resident 71's name, diagnoses, and diagnostic test performed and to be performed. During an observation in the hallway on 11/18/2024 at 11:24 AM and at 12:28 PM, Resident 71's Physician's Order Details were continuously left exposed and unattended on top of medication cart 1. . During an interview on 11/18/2024 at 1 PM with Licensed Vocational Nurse (LVN 3), LVN 3 confirmed Resident 71's appointment order was left on top of medication cart 1. LVN 3 stated he left out Resident 71's Physician's Order Details on top of the medication cart 1 to remind him to carry out all of Resident 71's orders since Resident 71 had just been discharged home. During an interview on 11/21/2024 at 8:29 AM with Registered Nurse Supervisor (RNS 1), RNS 1 stated resident files and personal information should not be left on top of the medication cart. RNS 1 stated it was against Health Insurance Portability and Accountability Act (HIPAA, an act of 1996 established federal standards protecting sensitive health information from disclosure without resident's consent) to leave Resident 71's file on top of the medication cart since it was a private document and should have not been left out. (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 record review of the facility's Policy and Procedure (P&P) titled, HIPPA Training Program, revised 4/2007, the P&P indicated all facility personnel are to ensure the confidentiality of our resident's protected health information (PHI).

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48143

Based on observation, interview, and record review, the facility failed to ensure residents were provided a comfortable and homelike environment (one that de-emphasizes the institutional character of the setting and is as close to that of the environment of a private home as possible) for five of seven sampled residents (Resident 8, 22, 43, 44, and 72) who were in attendance during the Resident Council (a group of residents who meet regularly to discuss concerns, suggest improvements, and plan activities related to their living situation within the facility) meeting by the facility failing to provide communal dining to their residents.

This deficient practice had the potential to result in decreased social interactions, decreased psychosocial wellbeing, and weight loss in residents.

Findings:

1. During a review of Resident 8's Admission Record indicated Resident 8 was admitted to the facility on [DATE] and re admitted on [DATE], with diagnoses that included acute respiratory failure with hypoxia (the lungs are unable to adequately exchange oxygen, leading to a dangerously low level of oxygen in the blood) and chronic obstructive pulmonary disease with acute exacerbation (a condition caused by damage to the airways or other parts of the lung, that leads to inflammation and other problems that block airflow and make it hard to breathe that can last for several days or weeks).

During a review of Resident 8's History and Physical (H&P), dated 8/27/2024, indicated Resident 8 does not have the capacity to understand and make decisions.

During a review of Resident 8's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 8/29/24, indicated Resident 8 does require set up and clean up assistance (helpers set up or cleans up; resident completes activity) with eating.

During an interview on 11/19/2024 at 10:36 AM, Resident 8 stated he want a communal dinning in the dining areas. Resident 8 stated there was no communal dinning since 2020.

2. During a review of Resident 22's Admission Record indicated Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung, that leads to inflammation and other problems that block airflow and make it hard to breathe), hepatic failure (a person's liver is failing to function properly).

During a review of Resident 22's History and Physical (H&P), dated 5/1/2024, indicated Resident 22 has capacity to understand and make decisions.

During a review of Resident 22's MDS, dated [DATE], indicated Resident 22 does require supervision (helpers provide verbal cues) with eating.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/2024, at 10:36 AM, Resident 22 stated he wants a communal dinning in the dining areas. Resident 22 stated common dining area is the place that he can meet up with his other friends in the facility so that he can feel less lonely by eating alone in his own room. Resident 22 stated there was no communal dinning since 2020. Resident 22 stated he wants the facility to resume communal dining for all residents. In addition, Resident 22 stated, the resident has talked to the Activity Director (AD) about resuming communal dining for a few times already and AD will just respond back that administrator has been made aware, but nothing was done. 3. During a review of Resident 43's Admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting left nondominant side, hypertensive heart disease (a group of conditions that can occur when chronic high blood pressure damages the heart) with heart failure (the heart is unable to pump enough blood to meet the body's needs). During a review of Resident 43's H&P, dated 5/22/2024, indicated Resident 43 has the capacity to understand and make decisions. During a review of Resident 43's MDS, dated [DATE], indicated Resident 43 does require supervision (helpers provide verbal cues) with eating. During an interview on 11/19/2024 at 10:36 AM, Resident 43 stated she always want to eat her meals at the dining room, she spends most of her time at the dining room for her activities and there is no reason for not serving their meals at the dining room after the activities. Resident 43 stated dinning in the activity room can reduce the chances of residents get hit by the wheelchair due to staffs are rushing to send all the residents back to their room for lunch and dinner after activities. Resident 43 stated she want the facility to resume the communal dinning for the residents inside the facility. 4. During a review of Resident 44's Admission Record indicated Resident 44 was admitted to the facility on [DATE], with diagnoses that included unspecified injury at unspecified level of cervical spinal cord (a damage to the spinal cord in the neck region without details about the precise level or type of damage involved), major depressive disorder (a serious mood disorder that involves a depressed mood and loss of interest in activities for at least two weeks). During a review of Resident 44's H&P, dated 7/24/2024, indicated Resident 44 has the capacity to understand and make decisions. During a review of Resident 44's MDS, dated [DATE], indicated Resident 44 has capacity to understand and make decisions and does require supervision (helpers provide verbal cues) with eating. During an interview on 11/19/2024 at 10:36 AM Resident 44 stated he always want to eat his meals at the dining room because it makes him feel good to eat with other people together and it can promote social life. Resident 44 stated there was no communal dinning since 2020 at the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a review of Resident 72's Admission Record indicated Resident 72 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (it occurs when problems with your metabolism cause brain dysfunction. Causes range from low blood sugar to excess fluid in the brain.) and cerebral ischemia (this occurs when the brain doesn't receive enough blood flow). During a review of Resident 72's H&P, dated 8/20/24, indicated Resident 72 has the capacity to understand and make decisions. During a review of Resident 72's MDS, dated [DATE], indicated Resident 72 does not require supervision with eating. During an interview on 11/19/2024 at 10:36 AM, Resident 72 stated he hates to eat inside his room because he feels lonely to eat by himself inside his room. Resident 72 stated he wants a communal dinning in the dining areas with other residents to enjoy his meals. Resident 72 stated he wants the facility to resume communal dining for all residents. During an interview on 11/21/2024 at 8:22 A.M. with the AD, the AD stated the facility closed the communal dining room since 2020 during the COVID-19 pandemic (viral respiratory disease that spreads worldwide). The AD stated they had not yet offered communal dining since then. The AD stated it was part of a homelike environment to offer communal dining and any resident who wants to be a part of lunch or dinner looks forward to it. The AD stated when communal dining is not provided then it could have resulted in increased depression, increased anxiety levels, decreased level of satisfaction with life, feelings of low self-worth, low self-esteem, and weight loss could develop as a result. During a review of the facility policy and procedure (P&P) titled, Home Like Environment, revised February 2021, indicated: 1. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary, and orderly environment, personalized furniture, and room arrangements. Provide contrasting colors (for example, plates that contrast with the table linens) 2. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. During a review of the facility policy and procedure (P&P) titled, Dignity, revised February 2021, indicated: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. 2. Residents are treated with dignity and respect at all times. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to ensure the preadmission screening and annual resident review assessment (PASARR, preventing individuals with mental illness, developmental disability, intellectual disability, or related conditions from being inappropriately placed in nursing homes for long term care) form was accurately completed for a resident who had a mental illness for one of four sampled residents (Resident 62). This deficient practice led Resident 62 to not receive the necessary and appropriate psychiatric (of or relating to the study of mental illness) level of treatment and evaluation in the facility. Findings: During a review of the Resident 62's Admission Record, the Admission Record indicated Resident 62 was admitted to the facility on [DATE], with diagnoses of psychosis (a mental disorder characterized by a disconnection from reality) and dementia (progressive brain disorder that slowly destroys memory and thinking skills). During a record review of Resident 62's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 9/26/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 62 had a psychiatric (relating to mental illness or its treatment)/mood disorder. The MDS also indicated Resident 62 did not have any mood and behaviors. During a review of Resident 62's Physician Order Summary Report, dated 5/15/2024, the Physician Order Summary Report indicated the following order: - Quetiapine Fumarate (Seroquel, medication commonly used for mood conditions) oral tablet 25 milligram (mg, unit of measurement): Give one tablet by mouth at bedtime for psychosis. During a review of Resident 62's care plan, dated 10/6/2024, the care plan indicated Resident 62 was taking an antipsychotic medication (drugs that work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking) for psychosis. The care plan indicated staff interventions included were to monitor behavior and assess every shift, remove resident from situation when combative, and reduce the following stressors that may be contributing to the resident's inappropriate behavior. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 62's PASARR Level I Screening, dated 5/15/2024, the record indicated the PASARR Level I was negative (there was no suspected mental illness or intellectual/developmental disability or related condition). The PASARR Level I Screening also indicated under Section three Resident 62 did not have a serious diagnosis of mental disorder such as depressive disorder (depressed mood or loss of pleasure or interest in activities for long periods of time), anxiety disorder (persistent and excessive worry that interferes with daily activities), panic disorder (an anxiety disorder with sudden attacks of panic or fear), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves)/schizoaffective disorder (a mental illness that causes loss of contact with reality), or symptoms of psychosis, delusions (believed to be true or real but is actually false or unreal), and/or mood disturbance. In addition, the PASARR indicated Resident 62 was not prescribed psychotropic medications (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) for mental illness. During a concurrent interview and record review of Resident 62's PASARR on 11/19/2024 at 3:22 PM with Admissions Coordinator (ADC), ADC stated Resident 62 had a diagnosis of psychosis and was prescribed with a psychotropic medication which were not reflected on the PASARR. During a concurrent interview and review of Resident 62's PASARR on 11/19/2024 at 3:40 PM with MDS Nurse (MDSN 1), MDSN 1 stated Resident 62's PASARR Level I Screening indicated that Resident 62 did not have a serious mental illness but Resident 62 had a diagnosis of psychosis upon admission. MDSN 1 also stated Resident 62's PASARR Level I Screening did not and should have indicated Resident 62 was prescribed a psychotropic medication upon admission. MDSN 1 stated the PASARR screening should be accurately completed to ensure correct placement of residents in the facility. During a review of the facility's Policy and Procedure titled, Admission Criteria, revised 3/2019, the policy indicated all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid PASARR process. The facility conducts a Level I PASARR screen for all potential admissions to determine if the individual meets the criteria for a MD, ID, or RD.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to develop a resident-centered comprehensive care plan (a care plan developed and implemented to meet the resident's preferences and goals, and addresses the resident's medical, physical, mental, and psychosocial needs) with individualized interventions for one (1) of 23 sampled residents (Resident 8) who was hard of hearing and refused to wear his hearing aid. This deficient practice had the potential to negatively affect and delay the delivery of care and services for Resident 8. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia (condition where there's not enough oxygen or too much carbon dioxide in the body), pneumonia (an infection that affects one or both lungs), and type 2 diabetes mellitus without complications(DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) . During a review of Resident 8's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/10/2024, the MDS indicated Resident 8 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 8 was dependent (helper does all of the effort) with oral hygiene, upper/lower body dressing, personal hygiene, and sit to stand. Resident 8 had moderate difficulty (speaker has to increase volume and speak distinctly) with hearing. During a review of Resident 8's Pure Tone Audiogram result, dated 5/8/2023, the result indicated Resident 8 had no hearing on the left ear and moderately severe hearing loss on the right ear. During an observation in Resident 8's room, on 11/18/2024, at 12:49 PM, Resident 8 sat on his wheelchair while waiting for his lunch to be served. An unidentified staff member entered Resident 8's room and spoke to Resident 8 in Spanish. Resident 8 did not answer the unidentified staff member. During an interview with Certified Nursing Assistant 1 (CNA 1), on 11/19/2024, at 2:55 PM, CNA 1 stated the staff need to speak louder when talking to Resident 8. CNA 1 stated Resident 8 was hard of hearing and could only hear from one ear. CNA 1 stated he did not know which side was the good ear. During an interview with MDS Nurse 1 (MDSN 1) on 11/20/2024, at 10:09 AM, MDSN 1 stated Resident 8 was hard of hearing. MDSN 1 stated Resident 8 could only hear from the right ear. During an interview with Responsible Party 3 (RP3), on 11/20/2024, at 3:39 PM, RP 3 stated Resident 8 can only hear from the right ear. RP 3 stated Resident 8 had hearing aids and ear amplifiers but refuses to use them. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with MDSN 1, on 11/20/2024, at 4PM, Resident 8's Care Plan for hearing, dated 7/3/2024, was reviewed. MDSN 1 stated Resident 8's care plan did not indicate which ear was the good ear. MDSN 1 stated Resident 8's care plan indicated Resident 8 had hearing aids but did not address Resident 8's refusal to wear them. MDSN 1 stated Resident 8's care plan for hearing was not resident-centered and comprehensive. MDSN 1 stated the care plan was important because it was a way to communicate the Resident 8's specific needs and interventions with facility staff. During an interview with Registered Nurse Supervisor 1 (RNS 1), on 11/21/2024, at 3:47 PM, RNS 1 stated Resident 8's care plan should be resident-centered and indicate which ear Resident 8 can hear from. RNS 1 stated Resident 8's care plan should indicate that Resident 8 refused to wear his hearing aids so an intervention can be put in place on how to better communicate with Resident 8. RNS 1 stated it was important for Resident 8 to have a resident-centered care plan so staff will know what intervention to follow to better communicate with Resident 8. During a review of the facility's policy and procedure (P&P), titled, Care plans, Comprehensive Person-Centered, revised on 3/2022, 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. The P&P indicated, the comprehensive, person-centered care plan describes services that are to be furnished to attain or maintain the Resident's highest practicable physical, mental, and psychosocial well-being.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45456 Based on observation and interview, the facility failed to provide a communication board (a device that displays photos, symbols, or illustrations to help people with limited language skills express themselves) for three (3) of four (4) sampled residents (Residents 41, 42 and 63) readily accessible with the language the residents were able to understand in accordance with the facility's policy. This failure had the potential for the residents to experience a delay in receiving appropriate care and treatment and feeling lonely and isolated due to the staff not being able to properly communicate with the residents. Findings: 1.During a review of Resident 41's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affect the left non- dominant side of the body, intraventricular hemorrhage (IVH, is bleeding inside or around the ventricles [spaces in the brain that contain the cerebral spinal fluid]), and left eye blindness During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool) dated 10/17/2024, the MDS indicated Resident 411 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 41 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) with toileting hygiene, lower body dressing, putting on and taking off footwear. Resident 41 also needed partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with oral hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed -to chair transfer, and walk 10 feet. During an observation in Resident 41's room and interview on 11/18/2024 at 12:17 PM, Resident 41 was observed sitting on her wheelchair. Communication board indicated a non-English language. During an interview with Responsible Party 1 (RP 1) on 11/18/2024 at 12:27 PM, RP 1 stated, Communication is our problem because a lot of staff do not speak the same language as my mom. My mom just gives up when the staff talks to her. My mom tries to communicate her needs to the staff just by pointing at things like tumbler for water and points to the restroom if she needed to use the restroom. Communication is the hardest issue that we had. During an interview with Activity Director (ACD) on 11/19/2024 at 3:09 PM, ACD stated the facility give communication binder upon resident's admission to the facility. ACD stated, staff do rounds to check if the residents have the communication binder in their room. ACD stated the communication binder is also kept in the activity room and sometimes in the nurse station. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with ACD on 11/19/2024 at 3:13 PM, ACD stated there were no communication board/binder in the residents' room not until yesterday morning when she placed them in the residents' rooms. During an interview with ACD on 11/19/2024 at 3:22 PM, ACD stated, the purpose of the communication board was to help the residents express their needs and concerns, likes, and dislikes. ACD added the residents can also express their emotions and staff can address their needs using the communication board, such as when the residents are tired and sleepy, or cold, if they want to go to the restroom, or ask for food if they are hungry. During a concurrent review of Resident 41's impaired communication care plan and interview with MDSN 1 on 11/21/2024 at 2:22 PM, MDSN 1 stated the care plan did not specifically indicate Resident 41's language. The care plan was not patient centered because, the care plan did not indicate the language that Resident 41 was speaking. 46919 2. During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), syncope (temporary loss of consciousness) and collapse, and history of falling. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was assessed having severely impaired cognitive skills (process of thinking and reasoning) for daily decision making. Resident 42's preferred a non-English language. Resident 42 needed or wanted an interpreter to communicate with a doctor or healthcare staff. Resident 42 required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, and tub/shower transfer. Resident 42 was independent (helper does all of the effort) with toileting hygiene, lower body dressing, personal hygiene, and sit to stand. During a review of Resident 42's care plan, dated 1/13/2024, the care plan indicated Resident 42 had impaired communication: sometimes understood/sometimes understands; unclear speech related to (r/t) dementia (a progressive state of decline in mental abilities), r/t language barrier- non-English language, and r/t visual impairment. Resident 42's care plan interventions indicated to use alternative communication tools as needed: (communication board, writing pad, signs, gestures, pictures). During a concurrent observation in Resident 42's room and interview with Responsible Party 2 (RP 2) on 11/18/2024, at 12:12 PM, Resident 42 and RP 2 were in Resident 42's room looking at a folder with pictures and words in a non-English language. RP 2 stated this was the first time she has seen the folder in Resident 42's room. During an interview with Certified Nursing Assistant 2 (CNA 2), on 11/18/2024, at 12:56 PM, CNA 2 stated the folder was dropped off in Resident 42's room by an unknown facility staff in the morning of 11/18/2024. CNA 2 stated Resident 42 only speaks non-English language and the folder was Resident 42's communication board (a sheet of symbols, pictures or photos that a resident will point to, to communicate with those around them). (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA 12, on 11/20/2024, CNA 12 stated communication boards are used to talk to residents and should always be at the resident's bedside. 48143 3. During a review of Resident 63's Admission Record, the Admission Record indicated Resident 63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the skin, contact with and suspected exposure to other communicable diseases, and tuberculosis of lung (a serious bacterial infection that can be fatal if left untreated). During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 was moderately impaired with cognitive skills for daily decision making. Resident 63 required helper to do more than half of the effort for resident for toileting, personal hygiene, change of position and transfer. Resident 63 is moderate dependent. During a concurrent observation in Resident 63's room and interview on 11/18/2024 at 9:48 AM, Resident 63 stated English is not his primary language and only understands a very little of English. Resident 63 stated, there is not much communication between himself and the staff. Resident 63 stated the staff do not use a communication board when attempting to speak with him. Resident 63 stated his sister helps him to communicate with the facility staff. Resident 63 stated the communication board on the bed side table was delivered to his bed side this morning not long before surveyor walked into his room. Resident 63 stated for most of the time, staff would come to his room and provide care without properly communicating with him. During a review of the facility's Policy and Procedure (P&P) titled, Translation and/or Interpretation of Facility Services, revised 11/2020, the P&P indicated to ensure that resident with Limited English Proficiency or who have hearing deficiencies, have the same access to Facility services as other residents, and translation and interpretation are provided in a way that is culturally relevant and appropriate to the Limited English Proficiency Individual. During a review of the facility's P&P titled, Accommodation of Residents' Communication Needs, revised 3/2017, the P&P indicated The facility provides assistance to residents with communication challenges through a number of adaptive services, and indicated procedures including staff will provide adaptive devices as needed to enable the resident to communicate as effectively as possible. The following are examples of adaptive devices the staff may provide the resident: Communication Boards/Charts.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on observation, interview, and record review the facility failed to ensure two of two sampled residents (Residents 78 and 22) were provided activities, based on comprehensive assessment and resident's preferences and interests in accordance with the facility policy. This deficient practice had the potential to negatively affect Residents 78 and 22's physical, mental, and psychosocial well-being. Findings: 1. During a review of the Resident 78's Admission Record, the Admission Record indicated Resident 78 was admitted to the facility on [DATE], with diagnoses of malignant neoplasm of nasopharynx (cancer that starts in the tissue connecting the back of the nose to the back of the mouth), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), adult failure to thrive (refers to a state where resident experiences a substantial decline in overall health and functional abilities), gastrotomy status (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage). During a record review of Resident 78's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 10/17/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 78 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, upper and lower body dressing, and personal hygiene (ability to maintain personal hygiene, including combing hair, shaving, washing/drying face, and hands). The MDS also indicated Resident 78 felt it was very important to do his favorite activities. During a concurrent interview and observation on 11/19/2024 at 10:59 AM in Resident 78's room, Resident 78 was lying in bed and stated he was not provided with any activities since being admitted on [DATE]. Resident 78 stated he stayed in bed all day. Resident 78 stated no one had ever offered any activities for him to participate in. Resident 78 stated he really wanted to listen to the radio, but he did not have a cell phone or a radio. Resident 78 stated he really wanted a radio placed next to him since he was hard of hearing. During an interview on 11/20/2024 at 8:19 AM with Certified Nursing Assistant (CNA 14), CNA 14 stated Resident 78 liked to stay in his bed. During an interview on 11/20/2024 at 8:31 AM with Activities Director (ACD), ACD stated Resident 78 spent most of his time sleeping in bed and had not participated in any activities in the activity room. ACD stated Resident 78 was newly admitted to the facility on [DATE], and she had not and should have offered his preferred activity of listening to the radio. A concurrent record review of Resident 78's MDS with ACD, ACD stated Resident 78 indicated it was very important to do the resident's favorite activities. 48143 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was admitted to the facility on [DATE] and re admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung, that leads to inflammation and other problems that block airflow and make it hard to breathe), and hepatic failure (a person's liver is failing to function properly). During a review of Resident 22's History and Physical (H&P), dated 5/1/2024, the H&P indicated Resident 22 has capacity to understand and make decisions. During a review of Resident 22's MDS, dated [DATE], indicated Resident 22 required supervision (helpers provide verbal cues) with eating, oral hygiene, shower, dressing, personal hygiene, bed mobility, transfer, and walking. During an interview on 11/19/2024 at 10:36 AM, Resident 22 stated he wants other activities besides Bingo, watching exercise videos and reading newspaper during the activity time with other residents. Resident 22 stated he wants mahjong (a game of skill, strategy, and luck), trips out of the facility, and visit to the nearby museum. Resident 22 stated there were candlelight dinners before at the front dining room, but there had no candlelight dinner now. Resident 22 stated the front dining room was now always occupied by the nursing students. During an observation on 11/19/2024 at 3:17 PM in the activity room, observed Activity Director (AD) was singing a song to the resident in front of the TV. There were a few of other residents sitting in the room with no other ongoing activities or games. During an observation on 11/20/2024 from 10:17 AM to 10:45 AM at the activity room, observed residents watching exercise video to exercise with the AD and one activity aid. Observed newspapers in the activity room all dated 11/15/2024. Observed TV channel in the activity room changed to cooking channel after the exercise video. During an interview with AD on 11/21/2024 at 8:22 AM in the activity room, AD stated it was hard to get four people to play the mahjong game, some time the residents fight during the game, so the mahjong game had stopped. AD stated there was a van for the residents' outings before, but the facility's van had broken down. AD stated the last administrator refused to fix the van, so the residents outing had stopped since then. AD stated a wide variety of activities can help residents stay active, happy, and they can promote resident's emotional health and sense of belongings. During a review of the facility's policy and procedure (P&P) titled, Activity Programs, revised date August 2006, the P&P indicated activity programs designed to meet the needs of each resident are available on a daily basis. 1. Activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. 2. Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs. 3. Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interests of each resident and include, as a minimum: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Activities that stimulate the cardiovascular system and assist with range of motion, such as exercise, movement to music, wheelchair basketball/volleyball, etc., are offered five to seven times per week. b. Intellectual activities that are mentally stimulating, such as current events, trivia, word games, book reviews, educational movies, etc., are provided five to seven times per week. c. Weather permitting, at least one activity a month is held away from the facility. d. Weather permitting, outdoor activities are held on a regular basis. e. At least one evening activity is offered per week, depending on population needs. f. Spiritual programming is scheduled to meet the religious needs of the residents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview, and record review, the facility staff failed to ensure one (1) of 23 sampled residents (Resident 8) received treatment and care in accordance with professional standards (the guidelines, policies, and procedure that define the expected behaviors and performance level for specific profession) of practice by failing to perform appropriate laboratory tests and monitor Resident 8's blood sugar (concentration of glucose in the blood). This deficient practice had the potential to result in a lack of or delay in assessing for possible complications of hypoglycemia (when the blood sugar is lower than normal) and hyperglycemia (high blood sugar) for Resident 8 which can lead to hospitalization . Findings: During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia (condition where there's not enough oxygen or too much carbon dioxide in the body), pneumonia (an infection that affects one or both lungs), and type 2 diabetes mellitus without complications(DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 10/10/2024, the MDS indicated Resident 8 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 8 was dependent (helper does all of the effort) with oral hygiene, upper/lower body dressing, personal hygiene, and sit to stand. During an interview with Minimum Data Set Nurse 1 (MDSN 1) on 11/20/2024, at 10:13 AM, MDSN 1 stated Resident 8 was diagnosed with diabetes when he was readmitted from the hospital on 7/3/2024. MDSN 1 stated Resident 8 received insulin (an injection medication used to control blood sugar) from 7/3/2024 to 7/17/2024. MDSN 1 stated Resident 8 did not have an order to monitor his blood sugar after the insulin was discontinued on 7/17/2024. MDSN 1 stated Resident 8 has not had any blood tests done to check his blood sugar since the insulin was discontinued on 7/17/2024 until 11/20/204. MDSN 1 stated Resident 8's blood sugar should be monitored at least quarterly if it is not being monitored daily. During an interview with the Interim Director of Nursing (IDON), on 11/21/2024, at 3:49 PM, the IDON stated it was important to continue to monitor Resident 8's blood sugar after the insulin was discontinued to make sure Resident 8's blood sugar was in the proper range. The IDON stated the physician should have been informed that Resident 8 did not have an order for blood sugar monitoring. The IDON stated he was not sure about the facility's policy and procedure (P&P) in diabetes management. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse Supervisor 1 (RNS 1), on 11/21/2024, at 3:55 PM, RNS 1 stated diabetes management included checking the resident's blood sugar and hemoglobin AIC (HbA1c- a blood test that measures the average blood sugar level over the past two or three months) on a regular basis. The RNS 1 stated it was important to monitor and check the resident's blood sugar to prevent hypoglycemia and hyperglycemia which can cause the resident to get sick and end up in the hospital. During a review of the facility's P&P, titled, Diabetes-Clinical Protocol, revised on 12/2020, the P&P indicated the following: For residents who meet the criteria for diabetes testing, the physician will order pertinent screening; for example, HbA1C, fasting plasma glucose (a measure of amount of glucose in the blood), or 2-hour plasma glucose with oral glucose load (a standardized amount of glucose that is administered to a reisdent during oral glucose tolerance test). As indicated, the Physician will order appropriate lab tests (for example, periodic finger sticks or HbA1C) and adjust treatment based on these results and other parameters such as glycosuria (sugar in the urine), weight gain or loss, hypoglycemic episode, etc. The physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the Medication Administration record and care plan.

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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** 48678 Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident (Resident 70), who was assessed at moderate to high risk for falls, had a floor matt placed in Resident 70's room as ordered by facility physician. This deficient practice had the potential to result in injury to Resident 70. Findings: During a review of Resident 70's Admission Record (a document containing diagnostic and demographic information), dated 11/20/2024, the record indicated Resident 70 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of lumbar (the lower back region of the spine) fracture (a partial or complete break in the bone), osteoarthritis (OA- is a degenerative joint disease that causes the cartilage in your joints to break down over time. It's the most common type of arthritis and can affect the hands, hips, knees, neck, and lower back), and history of falling. During a review of Resident 70's History and Physical (H&P- a term used to describe a physician's examination of a resident), dated 8/15/2024, the H&P indicated Resident 70 had history of generalized weakness and multiple falls. The H&P indicated Resident 70 can make needs known but not make medical decisions due to diagnosis of dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities). During a Review of Resident 70's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/20/2024, the MDS indicated Resident 70 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff to perform activities of daily living (ADLs). The MDS indicated Resident 70 had a history of previous falls (last month prior to admission). During a review of Resident 70's Orders (a set of written instructions from a doctor for a patient's care and treatment), dated 8/13/2024, the Orders indicated Resident 70 must have floor mats (A cushioned floor pad designed to help prevent injury should a person fall) every shift for fall risk. During a review of Resident 70's Fall Risk Assessment (a standardized questionnaire or set of tests used by healthcare professionals to evaluate a person's likelihood of falling, typically by assessing various factors like medical history, medication use, balance, gait, vision, and mobility, to identify potential risk factors and develop preventive strategies; essentially, it helps determine if someone is at low, moderate, or high risk of falling), dated 8/13/2024, the Fall Risk Assessment indicated Resident 70 was at moderate to high risk for falls, prompting additional preventative measures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/19/2024 at 9:29 AM in Resident 70's room, with Registered Nurse Supervisor 3 (RNS 3), the RNS 3 verified that Resident 70 had an order for floor mats because Resident 70 was at risk for falls, however, upon entering Resident 70's room, the RNS 3 stated, there were no floor mats in the room and Resident 70 should have floor mats if there was a physician order. The RNS 3 stated not following the physician's orders could result in Resident 70 acquiring an injury if Resident 70 fell on the floor, especially because Resident 70 has a history of osteoarthritis which could result in a fracture, causing pain and reducing quality of life for Resident 70. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated March 2018, the P&P indicated the facility will identify interventions to prevent residents from falling, and minimize complications from falling. Resident conditions that may contribute to the risk of falls include cognitive impairment and arthritis.

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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 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** 48143 Based on observation, interview, and record review, the facility failed to provide and accurately monitor fluid intake for one of one sampled resident (Resident 75) with fluid restrictions. This deficient practice had the potential to cause fluid overload (too much fluid in the body) or increase Resident 75's risk for dehydration (condition that occurs when the loss of body fluids, mostly water, exceeds the amount that is taken in). Findings: During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted to the facility on [DATE], with diagnoses that included end stage renal disease (a permanent condition that occurs when the kidneys are no longer able to function and require dialysis or a kidney transplant to survive), chronic kidney disease (a condition where the kidneys are damaged and can't filter blood properly), unspecified intellectual disabilities (a diagnosis given when it's difficult or impossible to assess the degree of intellectual disability in someone over the age of 5), and dependence on renal dialysis [(a state of requiring dialysis, (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) to maintain life] . During a review of the Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 10/7/2024, the MDS indicated Resident 75 had severely impaired (never/ rarely made decisions) cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 75 was dependent, (helper does all of the effort) with the eating, oral, toilet, personal hygiene, change of position, and transfer. During a review of Resident 75's Physician Orders, dated 11/18/2024, indicated Resident 75's fluid restriction was 1000 cubic centimeters (1000 cc) per 24 hours. During a concurrent observation and interview on 11/19/2024 at 5:07 PM with Certified Nurse Assistant 6 (CNA6) in front of Resident 75's room, observed CNA6 bought a dinner tray to Resident 75's bedside table with 1 main dish, 1 cup of yellow juice, 1 cup of soup, and 1 cup of dessert. The meal cart on Resident 75's dinner tray indicated renal diet with no milk, no dairy products. There was no indication of fluid restriction for 1000 cc per 24 hours. CAN 6 stated that she only knew Resident 75 was a dialysis resident, but she did not know Resident 75 was on any fluid restriction. CNA6 also stated there was no signage on the wall to indicate Resident 75 was on any fluid restriction. (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 11/20/2024 at 10:20 AM with Dietary Supervisor (DTS), DTS stated Resident 75 was on renal pureed (texture modified diet that consists of foods that are ground, pressed, or strained to a smooth, pudding consistency) diet with 1000 cc fluid restriction. DTS stated she followed doctor's order for 480 cc per day for Resident 75. DTS confirmed Resident 75 received 4 ounces (unit of measurement for liquid volume), (oz), (120 cc) of juice, 6 ounces (180 cc) of soup, and 4 ounces (120 cc) of pureed dessert for Resident 75's 11/19/2024's dinner tray. DTS stated, Resident (Resident 75) supposed to only have 4 oz of fluid for her dinner, nothing like bowl of soup and bowl of yellow dessert were supposed to be in the resident's dinner tray. DTS stated Resident 75 can be at risk for fluid overload which could affect the resident's health and cause other complications as a result of fluid overloaded. During an interview on 11/20/2024 at 4:16 PM with Licensed Vocational Nurse 9 (LVN 9), LVN 9 stated Resident 75 received 200 cc of water with some apple sauce for her last medication administration. LVN 9 acknowledged that the total fluid volume of 200 cc of water with some apple sauce that she gave to Resident 75 has exceeded the 120 cc restriction for the shift of 3PM-11PM. LVN 9 stated it can cause fluid overloaded, edema, maybe chest pain to Resident 75. During an interview on 11/21/2024 at 3:26 PM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 75 was on 1000 cc fluid restriction per 24 hours per doctor's order. RNS1 stated the extra fluid intake can cause fluid overload to Resident 75 which could cause chest pain, edema, and confusion from fluid overload. During a review of the facility's Policy and Procedure (P&P) titled, Food and Nutrition Services Policies and Procedures, revised August 2022, the P&P indicated the purpose of fluid restriction is to properly treat disease states which require restriction of fluids intake. The policy indicated the Food and Nutrition Services (FANS) will provide a standard amount of fluids to ensure that the prescribed fluid restrictions are maintained. Procedures included: 1. FANS Department monitors and/ or restricts fluid provided on patient trays as appropriate for their diet order. 2. Fluid restrictions are ordered by the physician and recorded in the Physician's Orders section of the medical record. 3. When a physician orders the following fluid restrictions, the total volume must be divided equally between FANS and Nursing. If additional fluid is needed by Nursing, Nursing staff is to notify FANS of the requested amount. 4. All patients, dependent on the fluid restriction volume, will receive on their meal tray: Total Fluids (ml):1000; Amount to FANS (ml) 500; Amount to Nursing (ml) 500 To further specify amounts given during meals see below: Total Fluids (ml):1000; Amount to FANS (ml) 500; breakfast (ml) 240; lunch (ml) 120; dinner (ml) 120. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. 'Fluids' are also those foods which are liquid at room temperature: soups, beverages, Jell-O, ice cream, sherbet, popsicles, etc.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review, the facility failed to implement the order for gastrostomy tube (GT, a tube inserted through the belly that brings nutrition directly to the stomach) feeding for one of two sampled residents (Resident 78) in accordance with the facility's policy. This deficient practice resulted in Resident 78 to not receive the volume of tube feeding formula ordered which could lead to weight loss and worsening malnutrition (serious condition that occurs when a resident's diet does not contain the right amount of nutrients). Findings: During a review of the Resident 78's Admission Record, the Admission Record indicated Resident 78 was admitted to the facility on [DATE], with diagnoses of malignant neoplasm of nasopharynx (cancer that starts in the tissue connecting the back of the nose to the back of the mouth), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), adult failure to thrive (refers to a state where resident experiences a substantial decline in overall health and functional abilities), gastrotomy status (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage). During a review of Resident 78's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 10/17/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 78 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for eating. The MDS also indicated Resident 78 had a feeding tube for acquiring nutrition. During a review of Resident 78's Nutritional Care, dated 10/13/2024, the record indicated Resident 78 was dependent on enteral feeding. During a review of Resident 78's Nutritional Care, dated 10/15/2024, the record indicated the following: 1. Resident 78's current weight was 95 pounds (lbs) with estimated nutritional needs of 1075 to 1290 kilocalories (kcal, unit of energy) and fluids of 1075 to 1290 milliliters (ml, unit of volume). 2. Resident 78's nutritional needs did not meet resident's current intake and needed to increase tube feeding to meet needs due to Resident 78's body mass index (BMI, medical screening tool to measure ratio of height to weight to estimate amount of fat) 15.3 which was low (normal BIM 18.5 to 25). 3. The nutritional intervention was to increase tube feeding Jevity (a calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term feeding) 1.2 at 50 ml/hour for 20 hours to provide 1000 ml, 1200 kcal, 55.5 gram (gm, unit of measurement) protein, 807 ml free water and flush with 125 ml every six hours for a total of 500 ml with a total water per day of 1307 ml. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 78's Physician Order Summary, the Physician Order Summary indicated an order on 10/17/2024 for Enteral Feeding Jevity 1.2 at 50 ml per hour for 20 hours via pump to provide 1000 ml/1200 kcal, 55.5 gm protein, 807 ml free water per day. The order was discontinued on 10/25/2024. During a review of Resident 78's Physician Order Summary, the Physician Order Summary indicated an order on 10/25/2024 for bolus feed (manual administration of a large dose of formula) Jevity 1.2 can 212 ml four times a day, flush 60 ml of water before and after each feeding. The order was discontinued on 10/28/2024. During a review of Resident 78's Nurses Progress Notes, dated 10/28/2024, the Nurses Progress Notes indicated Nurse Practitioner (NP) did not agree with dietary recommendation for the bolus feeding order and to reinstate Resident 78's previous order for Jevity 1.2 at 50 ml per hour for 20 hours via pump to provide 1000 ml/1200 kcal, 55.5 gm protein, 807 ml free water per day. During a concurrent review of Resident 78's Physician's Order Summary Report, Nurses Progress Notes, Resident's Weight, and interview with RNS 1 on 11/20/2024 at 10:05 AM with RNS 1, RNS 1 stated: 1. Resident 78's initial plan was to be discharged home with a bolus feeding. RNS 1 stated Resident 78's family wanted a bolus feed, and the Registered Dietician placed on order for the bolus feed on 10/25/2024. 2. Resident 78 initially weighed 95 lbs on 10/11/2024, 91 lbs on 11/4/2024, and 90 lbs on 11/16/2024. 3. On 10/28/2024, the NP did not agree with the enteral feeding bolus order and wanted to reinstate Resident 47's previous continuous feeding order. RNS 1 stated the licensed nurses did not and should have reinstated the feeding order for Jevity 1.2 at 50 ml per hour for 20 hours via pump to provide 1000 ml/1200 kcal, 55.5 gm protein, 807 ml free water per day. 4. NP had cancelled Resident 78's bolus feeding order on 10/28/2024 because Resident 78 had gotten sick. 5. On 11/9/2024 Resident 78 had a change in condition, was transferred to the General Acute Care Hospital (GACH) and was readmitted to the facility on [DATE]. RNS 1 stated when Resident 78 returned to the facility on [DATE], the licensed nurses continued Resident 78's enteral bolus feeding. RNS 1 stated the continuance of the bolus feeding and not the ordered continuous enteral feeding per NP order led to Resident 47 not receiving the right amount required for his nutritional needs. During a concurrent record review of Resident 78's Physician Order Summary Report and Nurses Progress Note and interview with Registered Dietician (RGD 2) on 11/21/2024 at 11:24, RGD 2 stated on 10/28/2024 the NP had an order to discontinue Resident 78's bolus feeding and to continue previous enteral feeding for Resident 78 to receive 1200 kcal. RGD 2 stated Resident 78 did not receive the correct kcal for 12 days. RDG 2 stated the licensed nursed did not follow the NP's order and could have resulted in Resident 78 losing weight. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's Policy & Procedure (P&P) titled, Enteral Nutrition, revised 11/2018, the P&P indicated enteral nutrition is ordered by the provider based on the recommendations of the dietician. The nurse confirms that the orders for enteral nutrition are complete. Complete orders include: a. The enteral nutrition product. b. Delivery site (tip placement). c. The specific enteral access device. d. Administration method (continuous, bolus, intermittent). e. Volume and rate of administration. f. The volume/rate goals and recommendations for advancement toward these; and g. Instructions for flushing (solution, volume, frequency, timing, and 24-hour volume).

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48678

Based on interview and record review, the facility failed to provide treatment and care to manage pain of one of two sampled residents (Resident 64) by failing to:

a. Administer Resident 64's methadone (medication used to treat moderate to severe pain. It can also treat narcotic drug addiction) on 11/18/2024 at 9 AM as ordered by the physician.

b. Reassess Resident 64's pain level after administering pain medication (methadone and Percocet [medication to treat moderate to severe pain]) on 11/21/2024 at 10 AM, to ensure pain medication was effective.

These deficient practices resulted in Resident 64 experiencing severe pain reporting a pain score of nine out of ten (9/10) on 11/18/2024 from 10 AM to 12:01 PM (2 hours and 1 minute). In addition, Resident 64 experienced pain with a score of eight out of ten (8/10) on 11/21/2024 from 10 AM to 1:09 PM (3 hours and 9 minutes) which resulted in physical distress to Resident 64.

Findings:

During a review of Resident 64's Admission Record (a document containing diagnostic and demographic information), dated 11/20/2024, the record indicated Resident 64 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of thoracic (middle region of the spine) fracture (a partial or complete break in the bone), osteomyelitis (a serious bone infection that causes inflammation and swelling of bone tissue) of the spine, right hip, and sacrococcygeal region (the region at the base of the spine, where the sacrum and coccyx [tailbone] meet), and opioid (a class of drugs that derive from, or mimic, natural substances found in the opium poppy plant. Opioids work in the brain to produce a variety of effects, including pain relief) dependence with withdrawal (Taking opioids over a long period of time produces dependence, such that when people stop taking the drug, they have physical and psychological symptoms of withdrawal such as muscle cramping, sweating, pain, diarrhea, and anxiety).

During a review of Resident 64's History and Physical (H&P- a term used to describe a physician's examination of a resident), dated 11/12/2024, the H&P indicated Resident 64 had history of chronic opioid use disorder, chronic back pain on methadone, and underwent a thoracic spine fusion (a surgical procedure that joins two or more vertebrae in the thoracic spine to eliminate movement between them).

During a Review of Resident 64's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/21/2024, the MDS indicated Resident 64 had intact cognition (ability to think and make decisions), and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff to perform activities of daily living (ADLs).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 64's Order Summary (a set of written instructions from a doctor for a patient's care and treatment), dated 11/17/2024, the Orders indicated to give methadone oral tablet 40 milligram (MG- a unit of volume) by mouth every 12 hours for pain/drug addiction. The Order Summary indicated to give Percocet (medication used to treat pain) 7.5-325 MG by mouth every six hours as needed for pain. During an interview on 11/18/2024 at 12:01 PM with Resident 64 in Resident 64's room, Resident 64 stated she had not yet received her morning medications which included methadone, and her pain score is at 9/10 (score of 10 means the most/ worst pain) since 10 AM. Resident 64 stated she had reported her pain of 9/10 to the licensed nurse at around 10 AM, but still had not received any pain medication. During an interview on 11/18/2024 at 12:39 PM with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated Resident 64 had reported her pain score of 9/10 around 10 AM today and was waiting for another LVN to become available to give Resident 64 her medications. LVN 8 stated the facility was short one LVN for the day to pass medication, that is why LVN 8had not administered Resident 64's pain medication when the reisdent verbalized pain around 9 AM. LVN 8 verified the physician's order for Resident 64's methadone should have been given to Resident 64 at 9 AM, and not 12 PM, and a delay in treating Resident 64's pain could result in uncontrollable pain and physical distress to the resident. During an interview on 11/19/2024 at 3:57 PM with the Director of Staff Development (DSD), DSD stated licensed nurses should administer scheduled medications ordered by the physician one hour before up to one hour after the indicated time of the order. DSD stated it is important to give medications on time to ensure medications have a therapeutic effect for the residents. DSD stated any licensed nurse, including the Registered Nurse Supervisor (RNS), and the Director of Nursing (DON) can both help pass out medication if there is not enough LVNs to pass medications. DSD stated giving Resident 64 medications three hours after they were scheduled (at 9 AM) can put Resident 64 at risk for uncontrolled pain leading to physical distress. During an interview on 11/20/2024 at 2:03 PM with the DON, the DON stated it is important to give scheduled medications as ordered by the physician to ensure effectiveness of the medication and to ensure consistency of treatment. The DON stated Resident 64 was put at high risk for exacerbation of symptoms related to opioid withdrawal (a set of symptoms that occur when someone stops or reduces their use of opioids after being physically dependent on them) and chronic pain because methadone is given to wean off (slowly decreasing the dosage before discontinuing the medication) the opioids and not giving it on time can cause withdrawals. The DON stated he was aware that they needed more licensed nurses to help with medication administration. During an interview on 11/21/2024 at 1:09 PM, with Resident 64 in Resident 64's room, Resident 64 stated she received her medication in the morning at 10 AM which included her pain medication, but her pain level was still an eight out of ten (8/10). Resident 64 stated I think getting up and walking would help relieve some pain off my back. The nurse never came back to check on me, they never usually do. Resident 64 stated the nurse did not come back to check if my pain had improved after giving the pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 2 PM with the Infection Prevention Nurse (IPN), the IPN stated she gave Resident 64 the resident's morning medications around 10 AM which included methadone and Percocet, along with other medications. The IPN stated she did not come back to check on Resident 64's pain score and to see if the medication was effective. IPN stated she should have gone back 30 minutes after administration of the pain medicine to reassess Resident 64 if the resident was still in pain and needed to provide additional intervention to manage the resident's pain. During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated April 2019, the P&P indicated staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered within one hour of their prescribed time. During a review of the facility's policy and procedure (P&P) titled Pain Assessment and Management, undated, the P&P indicated acute pain or worsening of chronic pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Pain management requires monitoring for the effectiveness of interventions, when opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48143 Based on observation, interview, and record review, the facility failed to ensure staffing information was posted and placed in a visible and prominent place on a daily basis. As a result, the total number of staff and the actual hours worked by the staff was not readily accessible to residents, staff, and visitors. Findings: During an observation on 11/18/2024 at 8:45 AM, the daily staffing information was not posted at the nursing station. During an interview on 11/18/2024 at 8:45 AM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated the Director of Staff Development (DSD) was responsible for posting the daily staffing at the nursing station. During an observation at the nursing station on 11/21/2024 at 8:42 AM, the daily staffing information posted was dated 11/19/2024. During an interview on 11/21/2024 at 10:43 AM with DSD, DSD stated she was in charge of posting the daily staffing information, which included the projected and actual hours. DSD stated she must post the daily staffing information every day and post it every morning. DSD stated she did not post the daily staffing information for the past few days due to not being able to find the form. DSD stated the purpose of posting the daily staffing information was to inform the resident, family, and staff about the staff to resident ratio and to show awareness that the facility has enough number of staff to provide care for the residents. During a review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, revised August 2022, indicated staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment. Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.

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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** 46919 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of all drugs and biologicals to meet the needs of two (2) of five sampled residents (Resident 31 and Resident 284) in accordance with the facility's policy and procedure (P&P) by failing to: 1. Ensure Resident 31 received the full dose of Humulin R insulin (a hormone that removes excess sugar from the blood) by not waiting approximately five (5) seconds before removing the needle after injection as indicated in the facility's policy and procedure (P&P). This deficient practice placed Resident 31 at risk of inadequate blood sugar management which can cause hyperglycemia (elevated blood sugar level) or hypoglycemia (low blood sugar level) 2.a. Administer Letrozole (a medication used to treat certain types of breast cancer (cells begin to grow out of control) for Resident 284 as ordered daily. 2.b. Administer clopidogrel bisulfate (a medication used to prevent blood clots) and metoprolol (a medication used to treat high blood pressure, chest pain, and heart failure [heart's inability to pump an adequate supply of blood]) within 60 minutes of scheduled time of 9 AM for Resident 284. These deficient practices had the potential for Resident 284 to experience chest pain, high blood pressure, and decline in overall health status. Findings: 1. During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included radiculopathy (a condition that occurs when a nerve root in the spine is damaged or compressed), diabetes mellitus (DM, persistently high levels of sugar in the blood), and other lack of coordination (a problem with movement, balance, or coordination). During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31 was assessed having moderately impaired cognitive skills for daily decision making. Resident 31 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene, and upper/lower body dressing. Resident 31 required supervision or touching assistance with eating, toileting hygiene, and toilet transfer. During a review of Resident 31's Order Summary Report, dated 11/21/2024, the Order Summary Report indicated a physician order, with a start date of 3/8/2024, for Humulin R injection 100 unit/milliliter (ml- unit of measurement) inject subcutaneously (beneath, or under, all the layers of the skin) before meals and at bedtime for DM, as per sliding scale (the progressive increase in the pre-meal or nighttime insulin dose based on pre-defined blood glucose ranges): If 70- 130 = 0 unit (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	131-180 = 2 units 181- 240 = 4 units 241-300 = 6 units 301-350 = 8 units 351-400 = 10 units Unit > (greater than) 400 = 12 units call physician (MD) During observation of medication administration (med pass) on 11/20/2024, from 11:27 AM to 11:39 AM, Licensed Vocational Nurse 5 (LVN 5) was observed preparing Resident 31's medications. LVN 5 prepared 4 units of Resident 31's Humulin R insulin injection pen. LVN 5 administered the insulin on Resident 31's lower left quadrant (the quarter of the abdomen on the left side, below the belly button, and left of the midline) and removed the needle immediately after injection. During an interview with LVN 5 on 11/20/2024, at 11:42 AM, LVN 5 stated he did not and should have left the needle in the skin for at least 5 seconds. LVN 5 stated it was important to leave the needle in the skin for at least 5 seconds to make sure the insulin was absorbed in the skin. LVN 5 stated Resident 31's blood sugar will remain high if the insulin was not absorbed properly which could lead to hypoglycemia. During an interview with the Registered Nurse Supervisor 1 (RNS 1) on 11/21/2024, at 4:06 PM, RNS 1 stated it was important to leave the needle in the skin for 5 seconds to make sure the insulin was absorbed. RNS 1 stated the insulin can leak out and Resident 31 will not receive the complete dose if the needle was removed too early or too fast. RNS 1 stated proper insulin administration and diabetic management was very important and should always be followed. During a review of the facility's P&P titled, Insulin Administration, revised on 9/2014, the P&P indicated during insulin administration the licensed nurse should depress the plunger and remove the needle after approximately five (5) seconds. During a review of the Humulin R manufacturer's insert, the insert indicated to insert the needle into the skin, push the Dose Knob (the knob you turn to select the insulin dose you need, located on one end of the insulin pen) all the way in, and to continue to hold the Dose Knob in and slowly count to 5 before removing the needle. 45456 2. During a review of Resident 284's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the breast (a cancerous tumor that originates in the breast tissue, meaning it is a form of breast cancer), chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs and peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel) (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 review of Resident 284's MDS, dated [DATE], the MDS indicated Resident 284 had intact cognitive skills for daily decision making. The MDS also indicated Resident 284 required substantial/ maximal assistance (helper does more than half the effort) with and lower body dressing, putting on and taking off footwear. The MDS also indicated Resident 284 required partial/ moderate with shower/bathe self, personal hygiene, sit to stand, chair/bed -to chair transfer, and tub/shower transfer, and walk 10 feet. During a review of Resident 284's Order Summary Report, dated 11/21/2024, the Order Summary Report indicated a physician order for the following medications: 1. Letrozole 2.5 mg, give 1 tablet by mouth one time a day for ovulation problem. 2. Clopidogrel Bisulfate 75 mg, give 1 tablet by mouth one time a day for prophylaxis (action to be taken to prevent disease). 3. Metoprolol Succinate 25 mg, give 1 tablet by mouth one time a day for hypertension. Hold if systolic blood pressure (SBP, pressure in the arteries when the heart contracts and pumps blood out) was less (<) than 110 or heart rate (HR) was less than 60. During a review of Resident 284's Medication Administration Record (MAR) from 11/1/2024 to 11/30/2024, the MAR indicated Resident 284 was scheduled to receive three medications at 9 AM: 1. Letrozole 2.5 mg 2. Clopidogrel Bisulfate 75 mg 3. Metoprolol Succinate 25 mg During a concurrent observation of the medication preparation and interview with Infection Preventionist Nurse (IPN) on 11/20/2024, at 10:06 AM, IPN stated Resident 284's Letrozole medication bubble pack was empty. IPN stated, There were no more medication in the bubble pack. We have to call the pharmacy to follow up. During an observation of the medication pass on 11/20/2023, at 10:12 AM, IPN administered the following medications: 1. Clopidogrel Bisulfate 75 mg, give 1 tablet by mouth one time a day for prophylaxis. 2. Metoprolol Succinate 25 mg, give 1 tablet by mouth one time a day for hypertension. Hold if SBP< 110 or HR<60. IPN did not administer Letrozole 2.5 mg to Resident 284. During an interview with IPN on 11/21/2024 at 8:27 AM, IPN stated, We missed a dose of Letrozole yesterday. I received it later in the day and I was not able to give it to the resident (Resident 284). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview with IPN, on 11/21/24 08:30 AM, IPN stated, It is important not to miss a medication dose for continuity of the dosing of the medication in the resident's system. If she did not get her medication, the resident might feel some symptoms for nasal allergies and pain. During a review of the facility's P&P, titled, Administering Medications, revised on 4/2019, the P&P indicated the following: Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143 Based on interview and record review, the facility failed to relay to the doctor the recommendations form the pharmacist indicated in the Medication Regimen Review (MRR, a monthly thorough evaluation by the consulting pharmacist of a resident's medication regimen, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for the month of September 2024 for two of five sampled residents (Resident 45 and 55). The MRR indicated to consider a gradual dose reduction (GDR - a periodic attempt to manage a resident's behavioral issues with a lower dose of medication) related to the use of Seroquel (an antipsychotic medication used to treat a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality also called psychosis) for Resident 55 and 45. This deficient practice had the potential to result in adverse reaction (unwanted, uncomfortable, or dangerous effects that a drug may have) to Resident 45 and 55 and unnecessary medications to the residents. Findings: 1. During a review of Resident 55's Admission Record indicated Resident 55 was admitted to the facility on [DATE], with diagnoses that included major acute respiratory failure with hypoxia (the respiratory system has trouble exchanging oxygen and carbon dioxide, resulting in low oxygen levels in the body's tissues), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), unspecified dementia (a general term for dementia that doesn't have a specific diagnosis), and sepsis (the body's extreme response to an infection). During a review of the Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/5/2024, indicated Resident 55 had severely impaired (never/ rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. Resident 55 required substantial and maximum assistance, (helper does more than half the effort) with the toilet, personal hygiene, change of position, and transfer. The MDS also indicated Resident 55 was receiving psychotropic medication [drug used to treat symptoms of psychosis, these include hallucinations (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real), delusions (false beliefs), and dementia (loss of the ability to think, remember, learn, make decisions, and solve problems)]. During a review of Resident 19's Physician Orders, dated 9/24/2024, the Physician Orders indicated Resident 55 to have Seroquel 25 milligrams (mg - a unit of measure for mass) two times a day (mg, a unit of measure) for agitation and dementia. During a review of Consultant Pharmacist's Medication Regimen Review, dated 9/24/2024, the MRR indicated to reevaluate if a gradual dose reduction is appropriate at this time due to Resident 55 has been on Seroquel 25 mg BID for the past 6 months. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/21/2024 at 3:51 PM, with the Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated the Director of Nurses (DON) supposed to review the monthly MRR, but the DON was on leave, so there was no one who reviewed the September 2024 MRR. RNS 1 stated if MRR result was not reviewed and if there were any irregularities or recommendation in the MRR were not relayed to the doctor and no action has been taken by the facility, it can cause medications overdose or medication misuse which can lead to resident harm, serious illness, and/ or worsening of condition. During an interview on 7/11/2024 at 9:27 AM, with the Administrator (ADM), ADM stated she still has the MRR of September 2024 in her computer, the MRR results were not reviewed for irregularities and/ or recommendations by the pharmacist therefore was not relayed to the doctor and was not carried out (implemented). 48678 2. During a review of Resident 45's Admission Record (a document containing diagnostic and demographic information), dated 11/21/2024, indicated Resident 45 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities). During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45 was severely impaired with cognitive skills for daily decision making. Resident 45 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff to perform activities of daily living (ADLs). Resident 45 did not have any mood or behaviors. During a review of Resident 45's Order Summary Report (a summary of all currently active physician orders), dated 6/25/2024, the Orders indicated Seroquel 12.5 mg by mouth at bedtime for psychosis manifested by combative to nurses during care. During a review of the consultant pharmacist's recommendation, dated 9/24/2024, indicated the consultant pharmacist asked the physician to consider reducing the dose of Resident 45's Seroquel or to indicate a clinical rationale as to why an attempt would be clinically contraindicated. During an interview on 11/21/2024 at 4:02 PM with the MDS Nurse 1 (MDSN 1), the MDSN 1 verified the pharmacist's recommendations to reduce Seroquel 12.5 mg due to behaviors have not been seen dated 9/1/2024. The MDSN 1 stated Social Services is responsible for contacting the physician to make the physician aware of the pharmacists' recommendations. The MDSN 1 verified that Resident 45 had not had any behaviors manifested by being combative with nurses for the month of September, October, and November 2024. The MDSN 1 verified that the physician had not acknowledged review of the pharmacist's recommendations, and verified the document provided by the pharmacist was blank and not signed by the physician. The MDSN 1 stated that the pharmacist's recommendations should have been provided to the physician by calling the physician's office and notify that the form needed to be filled out by the physician and faxed back to the facility by the end of the month (September 2024) at the latest. The MDSN 1 stated not notifying the physician about Resident 45's GDR recommendation put the resident at risk for getting a higher dose of Seroquel than the resident needed, which could result in unwanted side effects such as tardive dyskinesia (a chronic neurological disorder that causes involuntary, repetitive movements in the body. It's usually caused by taking antipsychotic drugs, also known as neuroleptics, for months or years, but it can also occur after short-term use). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 4:18PM with the Social Services Director (SSD), The SSD stated the process for ensuring the physician is made aware of the pharmacist's recommendations is to personally hand over the monthly pharmacist's recommendations to the physician and walk with the physician who is assessing residents, filling out and signing forms. The staff members responsible for informing the physician include the SSD and a Registered Nurse. The SSD stated she did not hand over the recommendations to the physician back in September, but she should have done so to prevent any delay in treatment or assessment of the residents. During a review of Resident 45's clinical record, no documentation was found indicating the physician responded to the consultant pharmacist's request to consider a GDR for Seroquel from 9/1/2024 through 11/21/2024. This review was verified by the MDNS 1 and the SSD who confirmed the physician had not reviewed the pharmacist's recommendations since 9/1/2024. During a review of the facility Policy and Procedure titled, Medication Regimen Review, revised May 2019, indicated the 1. The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. 2. Medication regimen reviews are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. 3. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. 4. If the identified irregularity represents a risk to a person's life, health, or safety, the consultant pharmacist contacts the physician immediately (within one hour) to report the information to the physician verbally and documents the notification. 5. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator. 6. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636 Based on interview and record review the facility failed ensure resident's drug regimen was free from unnecessary medication use for four (4) of five (5) sampled residents (Residents 47, 62, 33, and 45) in accordance with the facility policy by failing to ensure: 1.a. Resident 47 was free from taking two anxiety (a feeling of nervousness, panic, and fear) medications, Clonazepam (drug used to treat anxiety) and Lorazepam (drug used to relieve anxiety [fear characterized by behavioral disturbances] and treat insomnia caused by anxiety or temporary situational stress) 1.b. A specific indication for use/behavior was monitored for Resident 47's use of Clonazepam and Lorazepam. 1.c. Resident 47's behavior of crying for the use of Cymbalta (drug used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest] and anxiety) was monitored via hashmark from 10/21/2024 to 10/31/2024 1.d. Resident 47's behavior of paranoid delusions (fears, anxieties, and suspicions that someone may feel even though they are not based in reality) for the use of Zyprexa (drug used to treat several mental health conditions like schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder [mental disorder characterized by episodes of mania extreme highs] and depression]) was monitored via hashmark 11/1/2024 to 11/19/2024. 2. A specific indication for use/behavior was monitored for Resident 62's use of Quetiapine Fumarate (Seroquel, drug commonly used for mood conditions) for psychosis (severe mental condition in which thought, and emotions are so affected that contact is lost with reality). 3. Resident 33's behavior was monitored for the use of Escitalopram (a drug for treating depression and generalized anxiety disorder [GAD, is a mental health condition that causes people to experience excessive and persistent anxiety about everyday situations]). 4. A gradual dose reduction (GDR - a periodic attempt to manage a resident's behavioral issues with a lower dose of medication) was attempted for Resident 45's use of Seroquel (an antipsychotic [a class of medications that treat symptoms of psychosis and other mental health conditions] medication used to treat a severe mental condition in which thought and emotions are so affected that contact is lost with external reality also called psychosis]) or document a clinical rationale as to why an attempt would be contraindicated. The deficient practice increased the risk of Resident 47, 62, 33, and 45 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: 1. During a record review of Resident 47's Admission Record, the Admission Record indicated Resident 47 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder (a mental illness that causes loss of contact with reality, major depressive disorders (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a record review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment and tool), dated 10/26/2024, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 47 did not have any mood or behaviors. The MDS also indicated Resident 47 had psychiatric (of or relating to the study of mental illness)/mood disorders such as anxiety disorder, depression, psychotic disorder (other than schizophrenia), and schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves). During a record review of Resident 47's Physician Order Summary Report, for the month of November, the Physician Order Summary Report indicated the following orders: - On 11/18/2024: Clonazepam oral tablet 1 milligram (mg, unit of measurement): Give one tablet by mouth two times a day for anxiety for 14 days. - On 11/18/2024: Lorazepam oral tablet 0.5 mg: Give 1 tablet by mouth every six hours as needed for anxiety manifested by (m/b) restlessness for 14 days. - On 10/21/2024: Cymbalta (drug used to treat depression and anxiety) oral capsule delayed release particles 30 mg: Give 1 capsule by mouth one time a day for depression m/b crying. - On 10/23/2024: Zyprexa oral tablet 5 mg: Give 1 tablet by mouth every 12 hours for psychosis manifested by paranoid delusions. - On 10/21/2024: Monitor behavior episodes of anxiety m/b restlessness and tally with hashmarks for each episode on the Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) every shift. - On 10/21/2024: Monitor behavior episodes of depression m/b crying and tally with hashmarks for each episode on the MAR every shift. - On 10/21/2024: Monitor behavior episodes of psychosis (a mental disorder characterized by a disconnection from reality) m/b paranoia (thought process that causes an irrational suspicion or mistrust of others) and tally with hashmarks for each episode on the MAR every shift. During a record review of Resident 47's care plan, dated 10/21/2024, the care plan indicated Resident 47 had periods of anxiety m/b restlessness. The care plan interventions were for staff to administered medication as ordered, monitor and records episode(s) of behavior per facility policy/protocol, and monitor for potential adverse drug effects and complications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 47's care plan, dated 10/21/2024, the care plan indicated Resident 47 had periods of depression m/b crying. The care plan interventions were for staff to administer medication as ordered; monitor and record episode(s) of behavior per facility policy/protocol, monitor for potential adverse drug effects and complications; and monitor/document observed behavior and attempted interventions in resident record. During a record review of Resident 47's MAR for October 2024 the behavior monitoring are as follows: -From 10/21/2024 to 10/31/2024 there were no episodes for anxiety. -From 10/21/2024 to 10/31/2024 for depression there was one YES for 10/31/2024 7 AM to 3 PM shift. There was no tally with hashmarks to determine how many episodes Resident 47 had. -From 10/21/2024 to 10/31/2024, there were no episodes for psychosis. During a record review of Resident 47's MAR, Resident 47 received Clonazepam 1 mg on the following days: Received Twice: 10/22/2024, 10/23/2024, 10/24/2024, 10/25/2024, 10/27/2024, 10/28/2024, 10/29/2024, and 10/30/2024. Received once: 10/26/2024 and 10/31/2024. During a record review of Resident 47's MAR, Resident 47 received Lorazepam 0.5 mg on 10/23 at 10:02 PM. Resident 47's MAR for behavior monitoring on 10/23/2024 from 3 PM to 11 PM shift indicated Resident 47 did not have anxiety. During a record review of Resident 47's MAR for November 2024 the behavior monitoring are as follows: -From 11/1/2024 to 11/21/2024 for anxiety, there a YES on 11/6/2024 (3 PM to 11 PM), 11/19/2024 (7 AM to 3 PM) and 11/20/2024 (7 AM to 3 PM). -From 11/1/2024 to 11/19/2024 for depression a YES was indicated on 11/3/2024 (7 AM to 3 PM), 11/6/2024 (3 PM to 11 PM), 11/8/2024 (7AM to 3 PM), 11/9/2024 (7 AM to 3 PM), 11/15/2024 (7 AM to 3 PM), 11/18/2024 (7 AM to 3 PM), 11/19/2024 (7 AM to 3 PM). There was no tally with hashmarks to determine how many crying episodes Resident 47 had. -From 11/1/2024 to 11/19/2024 for psychosis, there was one YES on 11/19/2024 (7AM to 3 PM). There was no tally with hashmarks to determine how many paranoia episodes Resident 47 had. During a record review of Resident 47's MAR, Resident 47 received Clonazepam 1 mg on the following days: Received twice: 11/1/2024 to 11/9/2024 and 11/19/2024. Received once: 11/11/2024 and 11/18/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 47's MAR, Resident 47 received Lorazepam 0.5 mg on 11/18/2024 at 4:17 PM and 11/19/2024 at 12:25 PM. Resident 47's MAR for behavior monitoring on 11/18/2024 from 3 PM to 11 PM shift indicated Resident 47 did not have anxiety. During observations in Resident 47's room on the following days and times in Resident 47 was crying: - 11/18/2024 at 9:36 AM - 11/18/2024 at 12:27 PM - 11/19/2024 at 8:15 AM - 11/19/2024 at 3:02 PM - 11/19/2024 at 3:09 PM - 11/19/2024 at 3:39 PM - 11/19/2024 at 3:54 PM - 11/20/2024 at 9:20 AM - 11/20/2024 at 9:31 AM - 11/20/2024 at 4:27 PM - 11/20/2024 at 4:31 PM - 11/20/2024 at 4:35 PM - 11/20/2024 at 4:42 PM - 11/20/2024 at 4:49 PM During an interview on 11/21/2024 at 8:02 AM with Registered Nurse Supervisor (RNS 1), RNS 1 stated Resident 47 yells and cries. RNS 1 stated in the morning Resident 47 would cry and yell about twice every hour. RNS 1 stated Resident 47 cried and yelled daily. During an interview on 11/21/2024 at 9:16 AM with Restorative Nursing Aide (RNA 1), RNA 1 stated Resident 47 had a behavior of talking and crying. RNA 1 stated everyday Resident 47 had a habit of talking and crying which occurred every day. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview record review of Resident 47's MAR on 11/21/2024 with RNS 1, RNS 1 stated Resident 47 was currently prescribed with two anxiety medications on 11/18/2024, the Clonazepam and Lorazepam. RNS 1 also stated the MAR should and did not contain hashmarks for monitoring the behavior for the shift. RNS 1 stated when the licensed nurses document YES, the YES did not indicate how many behaviors Resident 47 had for his anxiety and depression. RNS 1 stated Resident 47 had daily behaviors of crying and yelling, and the licensed nurses had not monitored and documented correctly. RNS 1 stated based on Resident 47's observed behaviors, Resident 47 may need his medications to be adjusted. During a concurrent interview and record review of Resident 47's MAR on 11/21/2024 at 2:08 PM with the Interim Director of Nursing (IDON), the IDON stated the physician's order for Clonazepam should contain a specific behavior for anxiety in order for the licensed nursed to monitor and evaluate if the specific behavior decreased or increased and if the medication was effective. The IDON stated Resident 47 was also prescribed Lorazepam for anxiety m/b restlessness. The IDON stated the behavior of restlessness needed to be specific. The IDON stated monitoring the specific behavior would determine if the medication was working for the resident. The IDON stated Resident 47 was prescribed with two anxiety medications and should only be prescribed with one anxiety medication. During the same interview and record review of Resident 47's MAR on 11/21/2024 at 2:08 PM with the IDON, the IDON stated the monitoring for depression and anxiety was accomplished by hashmarks done by tallying. The IDON stated if the behaviors were not tallied via hashmarks, the facility would not be able to determine how many behavior episodes the resident had experienced. The IDON stated the tallying was needed to show an increase or decrease in the specific behavior for the physician to make an adjustment for the resident's medication regimen. The IDON stated the tallies from the behavior monitoring would also be used to see if the physician needed to increase or decrease the medications for a gradual dose reduction. 2. During a review of the Resident 62's Admission Record, the Admission Record indicated Resident 62 was admitted to the facility on [DATE], with diagnoses of psychosis (a mental disorder characterized by a disconnection from reality) and dementia (progressive brain disorder that slowly destroys memory and thinking skills). During a record review of Resident 62's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 62 had a psychiatric/mood disorder. The MDS also indicated Resident 62 did not have any mood and behaviors. During a review of Resident 62's Physician Order Summary Report, dated 5/15/2024, the Physician Order Summary Report indicated the following order: - Quetiapine Fumarate (Seroquel, drug used to treat certain mental conditions) oral tablet 25 mg: Give one tablet by mouth at bedtime for psychosis. - Monitor behavior episodes of restlessness/agitation and tally with hashmarks for every episode on the MAR every shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Consultant Pharmacist's Medication Regimen Review, dated 8/25/2024, the Consultant Pharmacist (CP) indicated Resident 62 received the antipsychotic Seroquel and needed to have evidence the behavioral symptoms present to the resident, or others and the symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions, paranoia or grandiosity [sense of superiority, uniqueness, or invulnerability that is unrealistic and not based on personal capability]). The current behavior restlessness/agitation does not justify the need for an antipsychotic medication. Please clarify and describe agitation to be more specific. During a review of Resident 62's care plan, dated 10/6/2024, the care plan indicated Resident 62 was taking an antipsychotic (drug that work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking) medication. The care plan interventions for staff were to monitor behavior and assess every shift. During a concurrent interview and record review of Resident 62's MAR on 11/21/2024 at 2:08 PM with the IDON, the IDON stated the physician's order for Seroquel should contain a specific behavior for psychosis in order for the licensed nursed to monitor the behavior to see if it decreased or increased and if the medication was effective. The IDON stated the behavior monitoring was accomplished by hashmarks done by tallying. The IDON stated tallying was needed to show an increase or decrease in the specific behavior for the physician to make an adjustment for the resident's medication regimen. The IDON stated the tallies from the behavior monitoring would also be used to see if the physician needed to increase or decrease the medications for a gradual dose reduction. During a review of the facility's Policy and Procedure (P&P) titled, Antipsychotic Medication Use, revised 8/2022, the P&P indicated diagnoses alone do not warrant the use of antipsychotic medication. Antipsychotic medications will generally only be considered if the following conditions are also met: - The behavioral symptoms present a danger to the resident or others; AND: o The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia, or grandiosity); or o Behavioral interventions have been attempted and included in the plan of care, except in emergency. The P&P also indicated all antipsychotic medications will be used within the clinically recommended dosage guidelines, or clinical justification will be documented for dosages that exceed guidelines for more than 48 hours. Residents will not receive as needed doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions including antipsychotic medications. During a review of the facility's P&P titled, Medication Regimen Reviews, revised 5/2019, the P&P indicated all residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 33's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), adjustment disorder with anxiety and depression. During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 had intact cognitive skills for daily decision making. The MDS also indicated Resident 33 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) shower/bathe self, lower body dressing, putting on and taking off footwear, personal hygiene, and tub/shower transfer. MDS also indicated substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) with oral hygiene, toileting hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, and chair/bed -to chair transfer. During a review of Resident 33's Order Summary Report, dated 9/25/2024, the report indicated Escitalopram Oxalate oral tablet 10 mg, give 1 tablet by mouth at bedtime for depression, started on 10/10/2024. During a concurrent interview with RNS 1 and record review of Resident 33's Physician's orders on 11/21/2024 at 5:25 PM, RNS 1 stated, Escitalopram was prescribed to Resident 33 for depression on 9/25/2024 but it did not include a specific indication/behavior for use behavior. RNS 1 stated there was no order for behavior monitoring for the use of escitalopram. RNS 1 stated Resident 33 should be monitored for a specific behavior manifestation of depression. RNS1 added, Resident 33 being overly concerned about her health should have been noted in the behavior monitoring for her depression. During a concurrent observation in Resident 33's room and interview with Resident 33 on 11/21/2024 at 5:29 PM, Resident was lying down on her bed. Resident 33 stated she was taking anti-depressant because she felt anxious. Resident 33 stated, I feel sad when I started taking the medications. I can barely eat my breakfast. I cannot take a bite. I feel sad because I cannot do physical therapy (PT, is a medical treatment used to restore functional movements, such as standing, walking, and moving different body parts). I was not able to walk properly, and I feel very stiff. 45456 3. During a review of Resident 33's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), adjustment disorder with anxiety and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 had intact cognitive skills for daily decision making. The MDS also indicated Resident 33 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) shower/bathe self, lower body dressing, putting on and taking off footwear, personal hygiene, and tub/shower transfer. MDS also indicated substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) with oral hygiene, toileting hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, and chair/bed -to chair transfer. During a review of Resident 33's Order Summary Report, dated 9/25/2024, the report indicated Escitalopram Oxalate oral tablet 10 mg, give 1 tablet by mouth at bedtime for depression, started on 10/10/2024. During a concurrent interview with RNS 1 and record review of Resident 33's Physician's orders on 11/21/2024 at 5:25 PM, RNS 1 stated, Escitalopram was prescribed to Resident 33 for depression on 9/25/2024 but it did not include a specific indication/behavior for use behavior. RNS 1 stated there was no order for behavior monitoring for the use of escitalopram. RNS 1 stated Resident 33 should be monitored for a specific behavior manifestation of depression. RNS1 added, Resident 33 being overly concerned about her health should have been noted in the behavior monitoring for her depression. During a concurrent observation in Resident 33's room and interview with Resident 33 on 11/21/2024 at 5:29 PM, Resident was lying down on her bed. Resident 33 stated she was taking anti-depressant because she felt anxious. Resident 33 stated, I feel sad when I started taking the medications. I can barely eat my breakfast. I cannot take a bite. I feel sad because I cannot do physical therapy (PT, is a medical treatment used to restore functional movements, such as standing, walking, and moving different body parts). I was not able to walk properly, and I feel very stiff. 48678 4. During a review of Resident 45's Admission Record (a document containing diagnostic and demographic information), dated 11/21/2024, indicated Resident 45 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities). During a review of Resident 45's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 12/1/2023, the H&P confirmed dementia diagnoses being treated with Donepezil (medication used to treat dementia), and stated Resident 45 does not have the capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/9/2024, the MDS indicated Resident 45 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 45 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff to perform activities of daily living (ADLs). Resident 45 did not have any mood or behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 45's Order Summary Report (a summary of all currently active physician orders), dated 6/25/2024, the Orders indicated on 6/25/2024, Resident 45 was prescribed Seroquel 12.5 milligrams (mg - a unit of measure for mass) by mouth at bedtime for psychosis manifested by combative to nurses during care. During a review of the consultant pharmacist's recommendation, dated 9/24/2024, indicated the consultant pharmacist asked the physician to consider reducing the dose of Resident 45's Seroquel or to indicate a clinical rationale as to why an attempt would be clinically contraindicated. During an interview on 11/21/2024 at 4:02 PM with the Minimum Data Set Nurse 1 (MDSN 1), the MDSN 1 verified the pharmacist's recommendations to reduce Seroquel 12.5 mg due to behaviors have not been seen dated 9/1/2024. The MDSN 1 stated Social Services is responsible for contacting the physician to make the physician aware of the pharmacist's recommendations. The MDSN 1 verified that Resident 45 had not had any behaviors manifested by being combative with nurses for the month of September, October, and November 2024. The MDSN 1 verified that the physician had not acknowledged review of the pharmacist's recommendations, and verified the document provided by the pharmacist was blank and not signed by the physician. The MDSN 1 stated that the pharmacist's recommendations should have been provided to the physician by calling the physician's office and notify that the form needed to be filled out by the physician and faxed back to the facility by the end of the month (September 2024) at the latest. The MDSN 1 stated not notifying the physician about Resident 45's GDR recommendation put the resident at risk for getting a higher dose of Seroquel than the resident needed, which could result in unwanted side effects such as tardive dyskinesia (a chronic neurological disorder that causes involuntary, repetitive movements in the body. It's usually caused by taking antipsychotic drugs, also known as neuroleptics, for months or years, but it can also occur after short-term use). During an interview on 11/21/2024 at 4:18 PM with the Social Services Director (SSD), The SSD stated the process for ensuring the physician is made aware of the pharmacist's recommendations is to personally hand over the monthly pharmacist's recommendations to the physician and walk with the physician who is assessing residents, filling out and signing forms. The staff members responsible for informing the physician include, the SSD and a Registered Nurse. The SSD stated she did not hand over the recommendations to the physician back in September, but she should have done so to prevent any delay in treatment or assessment of the residents. During an interview 11/21/2024 at 4:22 PM with the MDSN 1, the MDSN 1 stated a review of Resident 45's electronic medical administration record (eMAR), the eMAR indicated Resident 45 had continued to be administered Seroquel 12.5 MG after the pharmacist recommended for a GDR. The MDSN 1 stated that according to the eMAR, Resident 45 had not displayed any behaviors of psychosis from September through November 2024, yet the resident was still being administered Seroquel 12.5 MG. The MDSN 1 stated, this was most likely due to the physician not responding to the recommendations of the pharmacist in a timely manner which was due to their failure to follow up with the physician. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure (P&P) titled Tapering Medications and Gradual Dose Reduction, the P&P indicated during the first year in which a resident is admitted on a psychotropic medication, or after the facility has initiated such medication, the facility will attempt to taper the medication during at least two separate quarters with at least one month between the attempts, unless clinically contraindicated. The tapering may be considered clinically contraindicated if the continue use is in accordance with relevant standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause instability.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Four (4) medications errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error and yielded a facility medication rate of 16% for two (2) of 5 sampled residents (Resident 31 and Resident 284) observed during medication administration (med pass). 1. Licensed Vocational Nurse 5 (LVN 5) failed to ensure Resident 31 received the full dose of Humulin R insulin (a hormone that removes excess sugar from the blood) by not waiting approximately 5 seconds before removing the needle after injection. 2.a Infection Preventionist Nurse (IPN), failed to administer Letrozole (a medication used to treat certain types of breast cancer) for Resident 284 as ordered daily. 2.b IPN failed to administer clopidogrel bisulfate (a medication used to prevent blood clots) and metoprolol (a medication used to treat high blood pressure, chest pain, and heart failure) within 60 minutes of scheduled time of 9 AM for Resident 284. These deficient practices had the potential to result in harm to Resident 31 and Resident 284 by not administering medications as prescribed by the physician in order to meet their individual medication needs. Findings: 1. During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included radiculopathy (a condition that occurs when a nerve root in the spine is damaged or compressed), diabetes mellitus (DM, persistently high levels of sugar in the blood), and other lack of coordination (a problem with movement, balance, or coordination). During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31 was assessed having moderately impaired cognitive skills for daily decision making. Resident 31 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene, and upper/lower body dressing. Resident 31 required supervision or touching assistance with eating, toileting hygiene, and toilet transfer. During a review of Resident 31's Order Summary Report, dated 11/21/2024, the Order Summary Report indicated a physician order, with a start date of 3/8/2024, for Humulin R injection 100 unit/milliliter (ml- unit of measurement) inject subcutaneously (beneath, or under, all the layers of the skin) before meals and at bedtime for DM, as per sliding scale (the progressive increase in the pre-meal or nighttime insulin dose based on pre-defined blood glucose ranges): If 70- 130 = 0 unit (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	131-180 = 2 units 181- 240 = 4 units 241-300 = 6 units 301-350 = 8 units 351-400 = 10 units Unit > (greater than) 400 = 12 units call physician (MD) During observation of medication administration (med pass) on 11/20/2024, from 11:27 AM to 11:39 AM, Licensed Vocational Nurse 5 (LVN 5) was observed preparing Resident 31's medications. LVN 5 prepared 4 units of Resident 31's Humulin R insulin injection pen. LVN 5 administered the insulin on Resident 31's lower left quadrant (the quarter of the abdomen on the left side, below the belly button, and left of the midline) and removed the needle immediately after injection. During an interview with LVN 5 on 11/20/2024, at 11:42 AM, LVN 5 stated he did not and should have left the needle in the skin for at least 5 seconds. LVN 5 stated it was important to leave the needle in the skin for at least 5 seconds to make sure the insulin was absorbed in the skin. LVN 5 stated Resident 31's blood sugar will remain high if the insulin was not absorbed properly which could lead to hypoglycemia. During an interview with the Registered Nurse Supervisor 1 (RNS 1) on 11/21/2024, at 4:06 PM, RNS 1 stated it was important to leave the needle in the skin for 5 seconds to make sure the insulin was absorbed. RNS 1 stated the insulin can leak out and Resident 31 will not receive the complete dose if the needle was removed too early or too fast. RNS 1 stated proper insulin administration and diabetic management was very important and should always be followed. During a review of the facility's P&P titled, Insulin Administration, revised on 9/2014, the P&P indicated during insulin administration the licensed nurse should depress the plunger and remove the needle after approximately five (5) seconds. During a review of the Humulin R manufacturer's insert, the insert indicated to insert the needle into the skin, push the Dose Knob (the knob you turn to select the insulin dose you need, located on one end of the insulin pen) all the way in, and to continue to hold the Dose Knob in and slowly count to 5 before removing the needle. 2. During a review of Resident 284's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the breast (a cancerous tumor that originates in the breast tissue, meaning it is a form of breast cancer), chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs and peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel) (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 284's MDS, dated [DATE], the MDS indicated Resident 284 had intact cognitive skills for daily decision making. The MDS also indicated Resident 284 required substantial/ maximal assistance (helper does more than half the effort) with and lower body dressing, putting on and taking off footwear. The MDS also indicated Resident 284 required partial/ moderate with shower/bathe self, personal hygiene, sit to stand, chair/bed -to chair transfer, and tub/shower transfer, and walk 10 feet. During a review of Resident 284's Order Summary Report, dated 11/21/2024, the Order Summary Report indicated a physician order for the following medications: 1. Letrozole 2.5 mg, give 1 tablet by mouth one time a day for ovulation problem. 2. Clopidogrel Bisulfate 75 mg, give 1 tablet by mouth one time a day for prophylaxis (action to be taken to prevent disease). 3. Metoprolol Succinate 25 mg, give 1 tablet by mouth one time a day for hypertension. Hold if systolic blood pressure (SBP, pressure in the arteries when the heart contracts and pumps blood out) was less (<) than 110 or heart rate (HR) was less than 60. During a review of Resident 284's Medication Administration Record (MAR) from 11/1/2024 to 11/30/2024, the MAR indicated Resident 284 was scheduled to receive three medications at 9 AM: 1. Letrozole 2.5 mg 2. Clopidogrel Bisulfate 75 mg 3. Metoprolol Succinate 25 mg During a concurrent observation of the medication preparation and interview with Infection Preventionist Nurse (IPN) on 11/20/2024, at 10:06 AM, IPN stated Resident 284's Letrozole medication bubble pack was empty. IPN stated, There were no more medication in the bubble pack. We have to call the pharmacy to follow up. During an observation of the medication pass on 11/20/2023, at 10:12 AM, IPN administered the following medications: 1. Clopidogrel Bisulfate 75 mg, give 1 tablet by mouth one time a day for prophylaxis. 2. Metoprolol Succinate 25 mg, give 1 tablet by mouth one time a day for hypertension. Hold if SBP< 110 or HR<60. IPN did not administer Letrozole 2.5 mg to Resident 284. During an interview with IPN on 11/21/2024 at 8:27 AM, IPN stated, We missed a dose of Letrozole yesterday. I received it later in the day and I was not able to give it to the resident (Resident 284). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview with IPN, on 11/21/24 08:30 AM, IPN stated, It is important not to miss a medication dose for continuity of the dosing of the medication in the resident's system. If she did not get her medication, the resident might feel some symptoms for nasal allergies and pain. During a review of the facility's P&P, titled, Administering Medications, revised on 4/2019, the P&P indicated the following: Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure two (2) of five sampled residents (Resident 31 and Resident 284) were free from significant medication errors by failing to: 1. Administer Resident 31's of Humulin R insulin (a hormone that removes excess sugar from the blood) 4 units as indicated in the facility's policy and procedure (P&P) and manufacturer's guidelines. This deficient practice placed the resident at risk of inadequate blood sugar management, which can cause hyperglycemia (high blood sugar) and untreated can lead to complications, such as eye, kidney, or heart disease or nerve damage. 2.a. Ensure Resident 284's Mometasone spray (medication used to treat and prevent the symptoms of seasonal and year-round allergy symptoms) 50 micrograms (mcg- unit of measurement) was not expired when administered on [DATE] to [DATE]. 2.b. Ensure Resident 284's Clopidogrel Bisulfate (a medication used to prevent blood clots) 75 mg Metoprolol (a medication used to treat high blood pressure, chest pain, and heart failure) 25 mg medication was administered within 60 minutes of administration time 2.c. Ensure Resident 284's Letrozole (a medication used to treat certain types of breast cancer) 2.5 mg was administered as ordered daily. These deficient practices had the potential for Resident 284 to experience allergy symptoms, chest pain, high blood pressure, and decline in overall health status. Findings: Findings: 1. During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included radiculopathy (a condition that occurs when a nerve root in the spine is damaged or compressed), diabetes mellitus (DM, persistently high levels of sugar in the blood), and other lack of coordination (a problem with movement, balance, or coordination). During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31 was assessed having moderately impaired cognitive skills for daily decision making. Resident 31 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene, and upper/lower body dressing. Resident 31 required supervision or touching assistance with eating, toileting hygiene, and toilet transfer. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 31's Order Summary Report, dated [DATE], the Order Summary Report indicated a physician order, with a start date of [DATE], for Humulin R injection 100 unit/milliliter (ml- unit of measurement) inject subcutaneously (beneath, or under, all the layers of the skin) before meals and at bedtime for DM, as per sliding scale (the progressive increase in the pre-meal or nighttime insulin dose based on pre-defined blood glucose ranges): If 70- 130 = 0 unit ,d+[DATE] = 2 units 181- 240 = 4 units ,d+[DATE] = 6 units ,d+[DATE] = 8 units ,d+[DATE] = 10 units Unit > (greater than) 400 = 12 units call physician (MD) During observation of medication administration (med pass) on [DATE], from 11:27 AM to 11:39 AM, Licensed Vocational Nurse 5 (LVN 5) was observed preparing Resident 31's medications. LVN 5 prepared 4 units of Resident 31's Humulin R insulin injection pen. LVN 5 administered the insulin on Resident 31's lower left quadrant (the quarter of the abdomen on the left side, below the belly button, and left of the midline) and removed the needle immediately after injection. During an interview with LVN 5 on [DATE], at 11:42 AM, LVN 5 stated he did not and should have left the needle in the skin for at least 5 seconds. LVN 5 stated it was important to leave the needle in the skin for at least 5 seconds to make sure the insulin was absorbed in the skin. LVN 5 stated Resident 31's blood sugar will remain high if the insulin was not absorbed properly which could lead to hypoglycemia. During an interview with the Registered Nurse Supervisor 1 (RNS 1) on [DATE], at 4:06 PM, RNS 1 stated it was important to leave the needle in the skin for 5 seconds to make sure the insulin was absorbed. RNS 1 stated the insulin can leak out and Resident 31 will not receive the complete dose if the needle was removed too early or too fast. RNS 1 stated proper insulin administration and diabetic management was very important and should always be followed. During a review of the facility's P&P titled, Insulin Administration, revised on ,d+[DATE], the P&P indicated during insulin administration the licensed nurse should depress the plunger and remove the needle after approximately five (5) seconds. During a review of the Humulin R manufacturer's insert, the insert indicated to insert the needle into the skin, push the Dose Knob (the knob you turn to select the insulin dose you need, located on one end of the insulin pen) all the way in, and to continue to hold the Dose Knob in and slowly count to 5 before removing the needle. 45456 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 284's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the breast (a cancerous tumor that originates in the breast tissue, meaning it is a form of breast cancer), chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs and peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel) During a review of Resident 284's MDS, dated [DATE], the MDS indicated Resident 284 had intact cognitive skills for daily decision making. The MDS also indicated Resident 284 required substantial/ maximal assistance (helper does more than half the effort) with and lower body dressing, putting on and taking off footwear. The MDS also indicated Resident 284 required partial/ moderate with shower/bathe self, personal hygiene, sit to stand, chair/bed -to chair transfer, and tub/shower transfer, and walk 10 feet. During a review of Resident 284's Order Summary Report, dated [DATE], the Order Summary Report indicated a physician order for the following medications: 1. Mometasone spray 50 mcg 2. Letrozole 2.5 mg, give 1 tablet by mouth one time a day for ovulation problem. 3. Clopidogrel Bisulfate 75 mg, give 1 tablet by mouth one time a day for prophylaxis (action to be taken to prevent disease). 4. Metoprolol Succinate 25 mg, give 1 tablet by mouth one time a day for hypertension. Hold if systolic blood pressure (SBP, pressure in the arteries when the heart contracts and pumps blood out) was less (<) than 110 or heart rate (HR) was less than 60. During a review of Resident 284's Medication Administration Record (MAR), from [DATE] to [DATE], the MAR indicated Resident 284 was scheduled to receive three medications at 9 AM: 1. Clopidogrel Bisulfate 75 mg, give 1 tablet by mouth one time a day for prophylaxis. 2. Metoprolol Succinate 25 mg, give 1 tablet by mouth one time a day for hypertension. Hold if SBP< 110 or HR<60. 3. Letrozole 2.5 mg, give 1 tablet by mouth. During a review of the same MAR, from [DATE] to [DATE], the MAR indicated Resident 284 received Mometasone spray 50 mcg on [DATE] to [DATE]. During a concurrent observation of medication preparation and interview with Infection Preventionist Nurse (IPN) on [DATE] at 10:03 AM, IPN stated Resident 284's Mometasone nasal spray expired on ,d+[DATE]. The IPN stated the pharmacy delivered the expired medication to the facility on [DATE]. The IPN stated the facility staff did not check the expiration of the medication before administering the medication to Resident 284. IPN stated Resident 284 was administered the expired mometasone spray from [DATE] to [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation of the medication preparation and interview with Infection Preventionist Nurse (IPN) on [DATE], at 10:06 AM, IPN stated Resident 284's Letrozole medication bubble pack was empty. IPN stated, There were no more medication in the bubble pack. We have to call the pharmacy to follow up. During an observation of the medication pass on [DATE], at 10:12 AM, IPN administered the following medications: 1. Clopidogrel Bisulfate 75 mg, give 1 tablet by mouth one time a day for prophylaxis. 2. Metoprolol Succinate 25 mg, give 1 tablet by mouth one time a day for hypertension. Hold if SBP< 110 or HR<60. IPN did not administer Letrozole 2.5 mg to Resident 284. During an interview with the Director of Staff Development (DSD) on [DATE], at 10:25 AM, the DSD stated expired medication should not be administered to a resident. The DSD stated the resident should be assessed and the physician should be notified if an expired medication was administered. During an interview with IPN on [DATE] at 8:27 AM, IPN stated, We missed a dose of Letrozole yesterday. I received it later in the day and I was not able to give it to the resident (Resident 284). During the same interview with IPN, on [DATE] 08:30 AM, IPN stated, It is important not to miss a medication dose for continuity of the dosing of the medication in the resident's system. If she did not get her medication, the resident might feel some symptoms for nasal allergies and pain. During a review of the facility's P&P, titled, Administering Medications, revised on ,d+[DATE], the P&P indicated the following: Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and review, the facility failed to label and store drugs in locked compartments when the facility failed to: 1. Ensure safe drug storage by leaving two medications unattended on top of the medication cart. This deficient practice had the potential to result in other residents having access to medications causing adverse consequences or possible hospitalization if ingested. 2. Ensure the unopened insulin (a hormone that works by lowering levels of sugar in the blood) pens of Residents 75 and 48 were stored inside the refrigerator instead of inside the medication cart per manufacturer's guidelines. This deficient practice had the potential for loss of efficacy of the insulin injection. 3. Ensure the opened Resident 37's Ipratropium-Albuterol Solution (a medication that treats chronic obstructive pulmonary disease [COPD- a long-term lung disease causing difficulty breathing]) box, which expires 7 days after opening, was labeled with date opened for Resident 37. This deficient practice had the potential for loss of efficacy of the medication and unintentional medication administration of possibly expired medication. 4. Ensure the expired Mometasone spray medication (a medication sprayed in the nose to treat allergy symptoms) for Resident 284 was removed from the medication cart as indicated in the facility's policy and procedure (P&P). This deficient practice had the potential to result in the use of ineffective medications for Resident 284. 5. Maintain proper storage of five (5) medications and label opened medications for one of one medication storage room. These deficient practices had the potential for medication contamination and medication dispensing errors. Findings: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a concurrent observation of Medication Cart 2 (Med Cart 2) and interview with Licensed Vocational Nurse 3 (LVN 3), on 11/18/2024, at 8:35 AM, Med Cart 2 was left unattended outside the entrance of Room A. Med Cart 2 had nine tablets of Banophen diphenhydramine HCL (medication used to treat, sneezing, runny nose, itching, hives, and other symptoms of allergies and the common cold) tablets and two bisacodyl suppositories (a rectal medication used to treat constipation). LVN 3 stated the medications left on top of Med Cart 2 were house supply medications (stock supplies of over-the-counter medications). During a follow up interview with LVN 3, on 11/18/2024, at 3:39 PM, LVN 3 stated he left the medications unattended on top of Med Cart 2 because he had to get something at the Nurse's Station. LVN 3 stated medications should not be left unattended on top of the medication cart (med cart). During an interview with the Registered Nurse Supervisor 1 (RNS 1), on 11/21/2024, at 4:03 PM, the RNS 1 stated medication should not be left on top of the medication carts. RNS 1 stated medications should always be placed inside the med cart drawers. RNS 1 stated the med cart drawers should always be locked when unattended. RNS 1 stated the facility had confused residents who walks down the halls and can easily grab and take the medications left on top of the med carts. RNS 1 stated a resident can have an allergic reaction or can get very sick if the resident accidentally takes a medication not prescribed to the resident. 2. A. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD- a condition in which the kidneys lose the ability to remove waste and balance fluids), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and anemia (a condition where the blood does not carry enough oxygen to the rest of the body). During a review of Resident 75's Minimum Data Set (MDS- a resident assessment tool), dated 10/7/2024, the MDS indicated Resident 75 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 75 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, eating, upper/lower body dressing, and lying to sitting on side of bed. During a review of Resident 75's Order Summary Report, dated 11/21/2024, the Order Summary Report indicated a physician order, with a start date of 10/29/2024, for Insulin Regular Human Injection Solution inject as per sliding scale. 2.B. During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included ESRD, DM, and history of falling. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48 was assessed having severely impaired cognitive skills for daily decision making. Resident 48 was dependent with toileting hygiene, shower/bathe self, lower body dressing, and personal hygiene. Resident 48 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing, sit to stand, and chair/bed-to-chair transfer. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 48's Order Summary Report, dated 11/21/2024, the Order Summary Report indicated a physician order, with a start date 10/31/2023, for Humulin 70/30 Subcutaneous Suspension (70-30) 100 unit/milliliter (ml- unit of measurement) (Insulin NPH Isophane & Reg (Human)) inject 15 unit subcutaneously two times a day for DM, hold if blood sugar (BS) < (less than) 70. The Order Summary Reported also indicated a physician order, with a start date of 11/17/2023 for Humulin R Injection Solution 100 unit/ml (Insulin Regular (Human)) inject as per sliding scale: During the medication inspection of Medication Cart 2 (Med Cart 2), on 11/21/2024, at 2:04 PM, 2 unopened and undated Novolin R insulin pens and 1 unopened and undated Humulin insulin pen was noted one of the medication trays. The three insulin pens were placed in individual clear plastic bags with a blue sticker that indicated, Refrigerate Until Opened. During an interview with Licensed Vocational Nurse 7 (LVN 7), on 11/21/2024, at 2:44 PM, LVN 7 stated unopened insulin pens should be stored in the refrigerator. LVN 7 stated only used insulin pens can be stored in the medication carts. 3. During a review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), COPD, and DM. During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37 had intact memory and cognitive skills for daily decision making. The MDS also indicated Resident 37 was dependent with oral hygiene, toileting hygiene, lower body dressing, and personal hygiene. The MDS indicated, Resident 37 required substantial/maximal assistance with upper body dressing, sit to lying, and chair/bed-to-chair transfer. During a review of Resident 37's Order Summary Report, dated 11/21/2024, indicated a physician order, with a start date of 8/12/2024, for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 3 milligram (mg- unit of measurement)/3ml - 1 dose inhale orally via nebulizer (a device used for producing a fine spray of liquid, used for inhaling a medicinal drug) every 4 hours as needed for shortness of breath (SOB)/wheezing (breathing with a whistling or rattling sound in the chest). During the concurrent medication inspection of Med Cart 2 and interview with LVN 7, on 11/21/2024, at 2:35 PM, a box of Ipratropium-Albuterol solution was noted inside a medication tray. The box contained a foil packet with 3 plastic vials of Ipratropium-Albuterol solution inside. The box indicated an expiration date of 7 days from date opened. LVN 7 stated the box and the foil packetwas not labeled with open date. LVN 7 stated the Ipratropium-Albuterol indicated the vials expired 7 days after the open date. LVN 7 stated it was important for the Ipratropium-Albuterol box to to be labeled with date opened so that licensed nurses would know the expiration date of the medication. LVN 7 stated the effectiveness of the medication can be affected if the medication was expired. LVN 7 stated it will not benefit the health of Resident 37 if he took an expired medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Registered Nurse Supervisor 1 (RNS 1), on 11/21/2024, at 4:10 PM, RNS 1 stated expired medications should not be left in the medication cart. RNS 1 stated it was the licensed nurse's responsibility to check the medication cart and make sure the cart did not have expired medications. RNS 1 stated a licensed nurse can accidentally administer an expired medication to a resident if an expired medication was left inside the medication cart. RNS 1 stated the licensed nurse who opened the box of Ipratropium-Albuterol should have followed the instruction and should have written the opened date on the box and the packet to know when the medication expires. RNS 1 stated only used insulin pens should be stored in the medication cart. RNS 1 stated unopened and unused insulin pens should be stored in the refrigerator to maintain the potency of the insulin. RNS 1 stated the policy for medication storage was not followed by the facility staff. 45456 4. During a review of Resident 284's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the breast (a cancerous tumor that originates in the breast tissue, meaning it is a form of breast cancer), chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs and peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel) During a review of Resident 284's MDS dated [DATE], the MDS indicated Resident 284 had intact cognitive skills for daily decision making. The MDS also indicated Resident 284 was substantial/ maximal assistance with and lower body dressing, putting on and taking off footwear. Resident 284's MDS also indicated partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with shower/bathe self, personal hygiene, sit to stand, chair/bed -to chair transfer, and tub/shower transfer and walk 10 feet. During a concurrent observation of medication administration and interview with Infection Preventionist Nurse (IPN), on 11/20/2024 at 10:03 AM, IPN stated Resident 284's Mometasone nasal spray expired on 2/2024. The IPN stated the pharmacy delivered the expired medication to the facility. The IPN stated the facility staff who received the expired medication should have checked the expiration of the medication before placing it in the medication cart. During an interview with LVN 7, on 11/21/2024, at 2:48 PM, LVN 7 stated the medication cart should not store expired medications for the residents' safety. LVN 7 stated expired medications can accidentally be administered to residents if the licensed nurse does not check the expiration date. LVN 7 stated it is the responsibility of the licensed nurse who administers medications to make sure expired medications are removed from the medication carts. During a review of the facility's P&P, titled, Medication Labeling and Storage, revised on 2/2023, the P&P indicated the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. The nursing staff is responsible for maintaining medications storage and preparation areas in a clean, safe, and sanitary manner. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location. Multi-dose vials that have been opened or accessed (example needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. During a review of the facility's P&P, titled, Administering Medications, revised on 4/2019, the P&P indicated the following: No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. 44636 5. During an observation on 11/21/2024 at 2:51 PM with Registered Nurse Supervisor (RNS 1) the following medications were opened in the medication storage room: a. Open bottle of 1000 count Docusate Sodium (stool softener)100 milligram (mg, unit of measurement) labeled with open date of 10/21/2024. b. Opened unit dose blister pack originally containing 100 capsules of Diphenhydramine HCl (an antihistamine used to treat sneezing, runny nose, watery eyes, hives, skin rash, itching, and other cold or allergy symptoms) 25 mg with no label of open date, amd 16 capsules left inside. c. Opened box of 24 count of Loperamide HCl (used to treat diarrhea and symptoms of gas) 2 mg, with no label of date opened. d. Open bottle of 120 count Magnesium Oxide (used to treat or prevent low magnesium levels in the blood) 400 mg labeled with open date of 8/31/2024. e. Open bottle of Calcium Supplement (used to treat conditions caused by low calcium levels) 600 mg with open date 9/23/2024. During an interview on 11/21/2024 at 3:08 PM with RNS 1, RNS 1 stated the medication storage room should not contain any opened medication. RNS 1 stated if the licensed nurses needed the medications, then the licensed nurses need to store the medication in the medication cart. RNS 1 stated the opened medications should also be labeled with opened date and placed in the medication cart and not in the medication storage room. RNS 1 stated the nurses were taking the medication from the medication storage room and putting the medication into smaller bottles for their convenience. RNS 1 stated the transferring of medication containers could result in medication errors, contamination, and the medications could have different expiration dates. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's Policy and Procedure titled, Medication Labeling and Storage, revised 2/2023, the policy indicated medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The policy also indicated medications may not be transferred between containers.

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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** 48143 Based on observation, interview and record review, the facility failed to provide appropriate food preferences for one of 23 sampled residents (Resident 284). This deficient practice had the potential to result in decreased meal intake and can lead to weight loss and malnutrition (the condition that develops when the body is deprived of vitamin, minerals, and other nutrients it needs to maintain healthy tissue and organ function). Findings: During a review of Resident 284 Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the breast (a cancerous tumor that originates in the breast tissue, meaning it is a form of breast cancer), chronic obstructive pulmonary disease (COPD- is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel). During a review of Resident 284's MDS dated [DATE], the MDS indicated Resident 284 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 284 was substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) with and lower body dressing, putting on and taking off footwear. Resident 284's MDS also indicated partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with shower/bathe self, personal hygiene, sit to stand, chair/bed -to chair transfer, and tub/shower transfer and walk 10 feet. During an interview with Resident 284 on 11/18/2024 at 8:39 AM, Resident 284 stated her meals in the facility was terrible. Resident 284 stated she received most of the time are hamburger and sandwich with cheese for her meals since she got admitted at the facility. Resident 284 stated she cannot eat the hamburger and bread with cheese, these are not her regular foods, and that she told the certified nurse aids (CNAs) that the resident wants Chinese food, no hamburger, and no bread with cheese. During a dining observation of lunch on 11/18/2024 at 12:53 PM in Resident 284's room, observed Reisdent 284's lunch tray/food tray with 1 cup of water, 1 cup of juice, 1 cup of rice soup, 1 chocolate ice cream in a cup and a plate with rice, chicken, vegetables and a sliced of bread. In addition, menu card placed on the food tray indicated Asian food. Resident 284 stated she does not like her foods today including the juice served to her. Resident 284 stated she only eat the vegetable and the rice soup from her food tray today, and the chicken thigh served tasted very dry, bland and taste just like eating [NAME]. Resident 284 stated in her county, the do not eat bread for lunch, and the vegetable is very mushy and overcooked. Resident 284 stated foods served to her were more like junk foods and the meals served always appeal unappetizing and unpalatable. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 284 on 11/20/2024 at 10:36 AM in the activity room, Resident 284 stated her dinner from last night was similar from her yesterday's lunch which were vegetables and chicken thigh. Resident 284 dated the piece of her chicken was just smaller than the chicken thigh from her lunch, and that the chicken was very dry again. Resident 284 also stated the night snacks are almost the same every night, there is only peanut butter jelly sandwich every night. During a review of Resident 284's Care Plan dated 11/11/2024 at the Point Click Care system (a software platform designed for long-term care facilities like skilled nursing homes and assisted living communities, allowing caregivers to easily access and input patient health information with a simple point-and-click interface, streamlining tasks like resident assessments, care planning, medication management, and billing, all within a cloud-based system), there was no care plan that indicates for Reisdent 284's diet preference. During a review of the facility Policy and Procedure titled, Resident Food Preferences, dated 2001, indicated the individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. 1. Upon the resident's admission (or within twenty-four [24] hours after his/her admission) the dietitian or nursing staff will identify a resident's food preferences. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident's food and eating preferences in the care plan. 4. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. 5. The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. 6. The facility's quality assessment and performance improvement (QAPI) committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143 Based on observation, interview, and record review, the facility failed to ensure one of 23 sampled residents (Resident 286) was provided mechanically altered (texture of a diet is altered) diet as indicated on the physician's order. This deficient practice had the potential to cause Resident 286 to choke (severe difficulty in breathing because of a constricted/obstructed throat) which could lead to death. Findings: During a review of Resident 286's Admission Record, the Admission Record indicated Resident 286 was admitted to the facility on [DATE], with diagnoses that included type two diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or doesn't use it properly, resulting in high blood sugar levels), dysphagia (difficulty swallowing) and depression (a serious medical illness that negatively affects how you feel, the way you think and how you act). During a review of the Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/11/2024, indicated Resident 286 had severely impaired cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 286 was dependent, (helper does all of the effort) with the eating, oral, toilet, personal hygiene, change of position, and transfer. MDS indicated Resident 286 has mechanically altered diet. During a review of Resident 286's Physician Orders, dated 11/14/2024, indicated a diet order of Consistent Carbohydrate Diet (CCHO, diet that involves eating the same amount of carbohydrates at each meal and snack to help manage blood sugar levels) & No added salt (NAS) diet, pureed (smooth, uniform texture similar to pudding, without lumps, strings, skins, or seeds) texture, regular/thin consistency for wound and weight loss. During a concurrent observation in Resident 286's room and interview on with Certified Nurse Assistant 6 (CNA 6) on 11/19/2024 at 4:49 PM, CNA6 bought a dinner tray to Resident 286's bedside table with dinner card indicated cardiac regular. CNA6 stated the dinner tray was supposed to be for the next bed. CNA6 stated Resident 286 was supposed to have pureed diet and needed to be fed. CNA6 stated Resident 286 could have choked if was given the Regular texture diet instead of pureed diet as ordered. During an interview on 11/21/2024 at 3:16 PM with Registered Nurse Supervisor 1 (RNS1), RNS1 stated Resident 286 was supposed to have been given a mechanically altered diet, cardiac pureed meal tray. RNS1 stated Resident 286's food must be in a pureed format, because regular texture food can be a choking hazard to Resident 286.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with their policy and procedure by failing to: 1. Discard expired food and label food in the dry storage room, refrigerators, and freezers in the kitchen with item name, date opened and expiration date, and failed to 2. Ensure kitchen equipment and food carts were clean and free of food debris (leftover food particles). 3. Ensure electric fans were free form dust and were not stored in the kitchen dry storage room. 4. Ensure dietary staff (Cook 1 and Chef 1) perform hand hygiene (is the act of cleaning the hands with soap or handwash and water to remove viruses/bacteria/microorganisms, dirt, grease, or other harmful and unwanted substances stuck to the hands) and change gloves during cooking and tray line assembly. (the dates that are placed on food labels to ensure foods maintain best texture or taste and prevent food spoilage) These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization . Findings: During the initial observation in the kitchen and interview with [NAME] 1 on [DATE] at 7:50 AM, the food cart was observed with food debris left on the top surface. [NAME] 1 stated food cart was dirty because it was used to distribute the juice or trays to the residents for breakfast this morning. During a concurrent observation in the dry storage room and interview with [NAME] 1, on [DATE] at 7:53AM, the following were observed: a) One bag of used brown bread on the bread rack with no date open. [NAME] 1 stated, I used the bread for breakfast this morning, but I got busy, and I forgot to write the date opened. b) Three dusty food container lids were observed in the storage shelf containing buttermilk pancake mix, graham crackers, and vanilla wafers. a) Two plastic containers with plastic forks and spoons were left opened and not completely covered with a lid. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Two dusty electric fans were stored in the corner between the two food racks. [NAME] 1 stated, I do not know why the fans were placed in there. c) Dusty coffee machine and thermos were placed at the bottom of the food rack. d) Food cart with food debris, food bowl and knife were left in the middle of the dry storage room. e) Box of opened Styrofoam cups were left open on top of the food rack. f) Plastic cup lids were stored on an open food storage container. g) Two packs of bread rolls were left on top of the file binders. [NAME] 1 stated, The bread rolls should not be on top of the binder to prevent food contamination. h) Cheesecake powder bag has no open date on the storage bag. [NAME] 1 stated, We need to write the open date on the food packages, so we know if the items were expired to prevent food contamination. During a concurrent observation in the kitchen and interview with [NAME] 1 on [DATE] at 8:06 AM, the following kitchen equipment were observed: a) Microwave knob had dry white colored food debris. [NAME] 1 stated, It is just not clean right now. b) The top of the food processor had brownish orange food debris. c) Tabletop can opener blade had dry brownish orange food stains. Cook 1 stated, The kitchen equipment were dirty. They have dry food debris left on them. We should be cleaning them properly. During a concurrent observation in the kitchen and interview with Dietary Supervisor (DTS) on [DATE] at 8:11 AM, the following were observed inside Freezer 1: a) Cookie dough bag did not have a label to indicate date opened. b) A food storage bag had Sweet written on the outer side and an open date of ,d+[DATE]. DTS stated, That is sweet potato fries, and it will last up to six months. c) Ice cream box did not have a label to indicate date opened. d) A bag of onion hush puppies was not labeled with the name of the food item and date opened. DTS stated, We labeled the food inside, but when the bag becomes frozen the sticker comes off and gets lost in the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in the kitchen and interview with DTS on [DATE] at 8:20 AM, four boxes of gloves and two discolored mittens were placed on top of the food storage containers under the preparation table. DTS stated, Boxes of gloves should not be on top of the food containers under the table preparation to prevent food contamination. During a concurrent observation in the kitchen and interview with DTS on [DATE] at 8:23 AM, the garbage container was placed next to Freezer 2. DTS stated, Garbage can should not be next to the refrigerator to prevent food contamination. During a concurrent observation in the kitchen and interview with DTS on [DATE] at 8:31 AM, there was a bag of ground meat inside Freezer 2 without a label to indicate name of the food item and date food was prepared. DTS stated, It is a bag of ground chicken, and it was prepared yesterday. The staff probably just forgot to put the label. During a concurrent observation in the kitchen and interview with DTS on [DATE] at 8:24 AM, a container of soy sauce was leaking inside Refrigerator 2. DTS stated, It should be wiped and cleaned before storing inside the refrigerator. During a concurrent observation in the kitchen and interview with DTS on, [DATE] at 8:33 AM, inside Refrigerator 3 were two bowls with lids with a date of ,d+[DATE]. AS was written on the cover of the bowls. DTS stated, AS means apple sauce. The staff should have written the full name to make sure that the food label is correct. During observation in the kitchen on [DATE] at 12:02 PM, [NAME] 1 was wearing rubber mittens over the disposable gloves. [NAME] 1 removed the rubber mittens and proceeded touching the food trays with the same disposable gloves. During observation in the kitchen on [DATE] at 12:07 PM, [NAME] 1 used rubber mittens over the disposable gloves. [NAME] 1 removed the rubber mittens and used the kitchen tools with same disposable gloves. [NAME] 1 touched the oven handle with the same disposable gloves. During a concurrent observation in the kitchen and interview with Chef 1 on [DATE] at 12:16 PM, Chef 1 was using disposable gloves while touching the food trays. Chef 1 opened the refrigerator twice without changing her disposable gloves, then proceeded to scoop soup and put the lid on the soup bowl without changing her gloves. Chef 1 stated, We change our gloves every time we handle different kinds of food like meat or other food. We need to change gloves in between tasks to prevent food contamination. During an interview with DTS on [DATE] at 12:56 PM, DTS stated, We usually need to wear disposable gloves during food preparation. We just need stay on that task and not do something else. We need to change gloves in between tasks to prevent food contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Preventing Food Borne Illnesses, dated , d+[DATE], the P &P indicated Food will be protected from sources of possible contamination or deterioration throughout the food service process from purchasing to ware washing. Food is stored by methods that reduce deterioration, contamination, or loss. Food is prepared by methods that ensure safe, sanitary food products. Food service areas are protected from contamination by the proper disposal of wastes. Food preparation equipment. utensils and work surfaces are cleaned, sanitized, and properly stored between use. Dietary personnel frequently wash their hands by the approved hand washing procedure. During a review of the P&P titled, Storage of Food and Non-Food Supplies, dated ,d+[DATE], the P&P indicated all food and non- food items purchased for the dietary department will be properly stored. Perishable food will be kept refrigerated or frozen except during necessary periods of preparation and services. Procedures included: 2. Storage practices: d. Opened containers of food will be stored in tightly closed non-corrosive containers or in sealed plastic bags. No exposed food will be stored in the storeroom, refrigerator, or freezer. 3. Food storage area: a. The storeroom is clean, well-lighted, well ventilated . Opened dry staples (such as flour and sugar) are stored in labeled containers of corrosion- resistant materials with the tight-fitting lids. Original packaging materials should be removed. Portable bins or dollies are recommended. 1.) all containers are washed before refilling. Date and label containers . 4. Perishable storage . All walk-in freezer and refrigerator are properly lighted and clean. 1.) A best practice to clean refrigerator and freezer prior receiving deliveries. Containers are labeled, dated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on interview and record review, the facility failed to ensure two of 23 sampled residents (Residents 21 and 185) medical record is complete by failing to ensure Residents 21 and 185's Resident's Clothing and Possessions Form we're signed by the resident/ resident representative. This deficient practice placed Resident 21 and 185 at risk for loss or theft of belongings. Findings: 1. During a review of Resident 21's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body needs for blood and oxygen), chronic kidney disease (is a condition in which the kidneys are damaged and cannot filter blood as well as they should) and hypertensive heart disease (a long-term condition that develops over many years in people who have high blood pressure) During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool) dated 8/9/2024, the MDS indicated Resident 21 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 21 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on and taking off footwear, sit to stand, chair/bed -to chair transfer, toilet transfer, sit to lying, lying to sitting on side of the bed, chair/bed-to chair transfer and tub/shower transfer. During a concurrent interview with Registered Nurse Supervisor 1 (RNS 1) and record review on 11/21/2024 at 8:52AM, Resident 21's Resident's Clothing and Possessions Form was reviewed. The form did not have Resident 21 or the responsible party's signature. RNS 1 stated, the form was incomplete because the form is missing the family/Responsible Party or Resident 21's signature and the staff's signature. During an interview with RNS 1 on 11/21/24 at 8:53 AM, the facility should have completed the Resident's Clothing and Possessions Form to be able to monitor and ensure the facility is not missing Resident 21's property like a cellphone, or wedding ring. RNS 1 stated the facility must make sure the residents were able to take their personal property back home after stay in the facility or else if it is missing, the facility will have to pay for it or replace it. 2. During a review of Resident185's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included adult failure to thrive (FTT, a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), benign prostatic hyperplasia (BPH, also known as an enlarged prostate, is a noncancerous condition in which the prostate gland becomes larger than normal), and syncope (fainting or passing out) During a review of Resident 185's History and Physical (H&P) dated 11/13/2024, the H&P indicated, Resident 185 does not have the capacity to understand and make decisions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 185's Skilled Nurse's Notes dated 11/13/2024, the nurse's notes indicated Resident 185 was total dependent (helper does all of the effort, resident does none of the effort to complete the activity) in bed mobility, transfer, locomotion, and toileting. During a concurrent interview with RNS 1 and record review on 11/19/2024 at 3:56 PM, Resident's Clothing and Possessions Form was reviewed. RNS 1 stated, Resident 185's inventory form was incomplete because there was no staff signature on the witness area and there was no signature on the responsible party or the resident's signature. During an interview with RNS 1 on 11/19/2024 at 3:59 PM, RNS 1 stated, it is important to ensure the Resident's Clothing and Possessions form is completed because it is the proof of record of the Resident's belongings upon admission and during stay in the facility. RNS 1 stated the facility checks the form before the resident goes home and we can look at the form and stands as a proof if the resident's belongings were missing or complete. During a review of the facility's policy and procedure (P&P) revised on 8/2022, the P&P indicated the residents' personal belongings and clothing are inventoried and documented upon admission and updated as necessary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility staff failed to observe infection control measures in accordance with the facility policy by failing to : 1. Handle soiled linens in a safe and sanitary method while changing Resident 16's soiled bedding. 2. Clean and disinfect the glucometer (an instrument for measuring the concentration of glucose [sugar] in the blood) after use with Resident 31 and before returning it in the medication cart drawer. 3. Post an enhanced barrier precautions (set of infection control measures that use personal protective equipment [PPE] to reduce the spread of multi drug resistant organisms [MDRO, microorganisms that are resistant to multiple classes of antibiotics and antifungals, which could be difficult to treat and spread quickly]) signage by Resident 63's room who was on isolation precautions. 4. Licensed Vocational Nurse 4 (LVN 4) failed to perform hand hygiene before and after administering medications to Resident 40. 5. Infection Preventionist Nurse (IPN) failed to perform hand hygiene before and after administering medications to Resident 284 These deficient practices had the potential to put residents at higher risk for healthcare associated infections and potential spread of infections in the facility. Findings: 1. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a long-term lung disease causing difficulty breathing), type 2 diabetes mellitus without complications (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and essential hypertension (HTN- high blood pressure). During a review of Resident 16's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 8/8/2024, the MDS indicated Resident 16 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 16 required substantial/maximal assistance (helper does more than half the effort) with eating, upper body dressing, and sit to stand. Resident 16 was dependent (helper does all of the effort, Resident does none of the effort to complete the activity) with toileting hygiene, lower body dressing, personal hygiene, and chair/bed-to-chair transfer. During a concurrent observation and interview with Certified Nursing Assistant 2 (CNA 2) on 11/18/2024, at 9:41 AM, CNA 2 exited Resident 16's room while holding linen close to her body and touching her scrubs. CNA 2's did not have gloves on while she held the linen. CNA 2 placed the linen in the dirty linen bin. CNA 2 stated the linen she placed in the dirty linen bin were Resident 16's dirty linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Staff Development (DSD), on 3:45 PM, the DSD facility staff should wear gloves while handling dirty laundry. The DSD stated dirty linen should be placed in a plastic bag after removed from the bed. The DSD stated dirty linen should never touch the clothing of facility staff. The DSD stated the facility staff's clothing was considered dirty and contaminated if the dirty linen touched the staff's clothing. The DSD stated residents can get infected with bacteria and viruses if they get in contact with the facility staff's dirty clothing. The DSD stated residents can get sick and end up in the hospital from the infection. During an interview with the Registered Nurse Supervisor 1 (RNS 1), on 11/21/2024, at 4:01 PM, RNS 1 stated facility staff's clothing should not touch dirty linen because the facility staff's clothing can get contaminated with the infection or bacteria on the dirty linen. RNS 1 stated facility staff can transfer the infection to the residents while providing care. During a review of the facility's P&P, titled, Laundry and Bedding, Soiled, revised on 9/2022, the P&P indicated the following: Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. All used laundry is handled as potentially contaminated using standard precautions (example: gloves, and gowns when sorting). Contaminated laundry is bagged or contained at the point of collection (example: location where it was used). Contaminated linen and laundry bags/containers are not held close to the body or squeezed during transport. 2. During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included radiculopathy (a condition that occurs when a nerve root in the spine is damaged or compressed), DM, and other lack of coordination (a problem with movement, balance, or coordination). During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31 was assessed having moderately impaired cognitive skills for daily decision making. Resident 31 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene, and upper/lower body dressing. Resident 31 required supervision or touching assistance with eating, toileting hygiene, and toilet transfer. During a review of Resident 31's Order Summary Report, dated 11/21/2024, the Order Summary Report indicated a physician order, with a start date of 3/8/2024, for Humulin R injection 100 unit/milliliter (ml- unit of measurement) inject as per sliding scale: If 70- 130 = 0 unit 131-180 = 2 units 181- 240 = 4 units (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	241-300 = 6 units 301-350 = 8 units 351-400 = 10 units Unit > (greater than) 400 = 12 units call physician (MD) subcutaneously (beneath, or under, all the layers of the skin) before meals and at bedtime for DM. During a concurrent observation of Resident 31's insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration and interview with Licensed Vocational Nurse 5 (LVN 5), on 11/20/2024, at 11:42 AM, LVN 5 checked Resident 31's blood sugar level using the glucometer. LVN 5 administered Resident 31's insulin and placed the glucometer on top of the medication cart after exiting Resident 31's room. LVN 5 did not clean and disinfect the glucometer before placing it back in the medication cart drawer. LVN 5 stated the glucometer should be disinfected before placing it back in the drawer. LVN 5 stated it was important to clean and disinfect the glucometer after use to stop the spread of infection and spread of blood borne pathogens (a virus or bacteria that can cause disease in humans and is carried in blood or other bodily fluids). During an interview with the Registered Nurse Supervisor 1 (RNS 1) on 11/21/2024, at 4:06 PM, RNS 1 stated it was the responsibility of the licensed nurse to disinfect the glucometer before and after use. RNS 1 stated facility staff should disinfect the glucometer before placing it back in the drawer because it can have blood and can contaminate the other items in the drawer. RNS 1 stated other residents can get sick from getting exposed with the contaminated glucometer. During a review of the facility's P&P, titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised on 10/2018, the P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. The P&P indicated, Reusable items are cleaned and disinfected or sterilized between residents. During a review of the facility's P&P, titled, Standard Precautions, revised on 10/18/2024, the P&P indicated, Resident-care equipment soiled with blood, body fluids, sections, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments. 48143 3. During a review of Resident 63's Admission Record, the Admission Record indicated Resident 63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the skin, contact with and suspected exposure to other communicable diseases, and tuberculosis of lung (a serious bacterial infection that can be fatal if left untreated). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 was moderately impaired with cognitive for daily decision making. Resident 63 required helper to do more than half of the effort for resident for the toilet, personal hygiene, change of position and transfer. MDS indicated Resident 63 is on isolation or quarantine for active infectious disease. MDS indicated Resident 63 has a personal history of tuberculosis of lung. During an observation in front of Resident 63's room on 11/18/2024 at 8:31 AM, observed a posting indicating Isolation Room and a yellow triangle with the exclamation mark on top of the wording. During a concurrent observation in front of Resident 63's room and an interview with MDS Nurse 1 (MDSN 1) on 11/18/2024 at 10:02 AM, MDSN 1 stated she has to put a signage indicating the particular PPE to use prior to going inside the room. MDSN 1 stated there has no proper signage for infection precaution for Resident 63's room. During a review of Resident 63's Care Plan dated 9/10/2024, there was no care plan that indicates for the isolation precaution for Resident 63. During an interview on 11/21/2024 at 5:44 PM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 63 is in isolation precaution for chronic wounds, chronic tuberculosis in the bone and sepsis (a life-threatening blood infection). RNS 1 stated there was supposed to be an enhanced barrier precautions sign to remind nurses, staff, and visitors to wear gowns, gloves, and wash hands before and after entering the resident's room for precaution purpose. During a review of the facility Policy and Procedure titled, Enhanced Barrier Precautions, dated October 2024, indicated: EBP (Enhanced barrier precautions) signage (see Appendix) will be prominently displayed in designated areas to remind staff and visitors of the appropriate steps for using Enhanced Barrier Precautions. Enhanced barrier precautions should be used for the duration of a resident's stay in the facility. Infection Preventionist periodically monitor and assess the adherence to the precautions and determine the need for additional training and education. Staff are provided training Enhanced Barrier precautions including but not limited to the use of Personal Protective Equipment (PPE), on hire and at least annually and are expected to comply with precautions. 45456 4. During a review of Resident 40 Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body needs for blood and oxygen), adult failure to thrive (FTT, a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 21 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 40 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, sit to lying, lying to sitting on side of the bed, chair/bed-to chair transfer and tub/shower transfer. During an observation of medication administration on 11/19/2024 at 4:20 PM, LVN 4 did not perform handwashing before preparing Resident 40's medications. During a concurrent observation and interview with LVN 4 on 11/19/2024 at 4:29 PM, LVN 4 did not perform hand hygiene after administering medications to Resident 40 and went directly to her computer to sign the medications she administered to Resident 40. LVN 4 stated, To prepare for medication administration, first we should sanitize everything (pertaining to the top surface of her medication cart and the medicine tray) before anything else. Then perform hand hygiene before starting the medication administration. During an interview with LVN 4 on 11/19/2024 at 4:30 PM, LVN 4 stated, I should have done the hand hygiene before leaving the room because it is infection control. We do not want to bring any germs anywhere near the residents. I forgot to do the hand hygiene earlier because I was nervous before we started. 5. During a review of Resident 284 Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the breast (a cancerous tumor that originates in the breast tissue, meaning it is a form of breast cancer), chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs and peripheral vascular disease (is the reduced circulation of blood to a body part other than the brain or heart caused by a narrowed or blocked blood vessel) During a review of Resident 284's MDS dated [DATE], the MDS indicated Resident 284 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 284 was substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) with and lower body dressing, putting on and taking off footwear. Resident 284's MDS also indicated partial/ moderate assistance (helper does less than half the effort, helper lifts, hold, or supports trunk or limbs but provides less than half the effort) with shower/bathe self, personal hygiene, sit to stand, chair/bed -to chair transfer, and tub/shower transfer and walk 10 feet. During an observation of medication administration on 11/20/2024 at 10:03 AM, IPN did not perform handwashing before preparing Resident 284's medications. During an observation of medication administration on 11/20/2024 at 10:13 AM, IPN did not perform hand hygiene before going inside Resident 284's room to administer the resident's medications. During an observation of medication administration on 11/20/2024 at 10:15 AM, IPN came out of Resident 284' room after administering Resident 284's medications. IPN used the computer right away to sign the medications that she administered to Resident 284 without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with IPN on 11/20/2024 at 10:17 AM, IPN stated, We should perform hand hygiene or hand washing before we walk in and after walking out of a resident's room. During an interview with IPN on 11/20/2024 at 10:20 AM, IPN stated, I usually use hand sanitizer during medication administration, but I did not apply hand sanitizer before and after administering medication to the resident. It is important to perform hand hygiene before and after resident's care, so we do not pass any germs from one resident to another. During a review of the facility's policy and procedure (P&P) titled Administering Medications revised on 4/2019, the P&P indicated Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.

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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.

44636

Based on observation, interview and record review, the facility failed to ensure 10 of 36 rooms (17, 42, 43, 44, 51, 52, 53, 54, 62 and 63) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms.

This deficient practice had the potential of not providing the required space for resident's personal care, or the ability to permit the use of residents' care devices, room for visitors, and the use of personal furniture.

Findings:

During a review of the facility's room waiver (a legal document which allows to give up certain legal rights or claims), dated 11/18/2024, the waiver indicated that these rooms did not meet the Federal requirements according to 42 CFR 483.70 (80 square feet per bed). The room waiver also indicated these rooms had adequate space for nursing care, and the health and safety of the residents occupying these rooms are not in jeopardy. The room waiver further indicated these rooms were in accordance with the special needs of the residents and would not have an adverse effect on the residents' health and safety or impede the ability of any resident to attain his or her practical well-being. The room waiver showed the following:

Room Sq. Ft. Beds

17 153.28 2

42 319.88 4

43 312.47 4

44 313.99 4

51 316.25 4

52 311.46 4

53 311.12 4

54 319.88 4

62 311.28 4

63 314.65 4

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview with the Administrator (ADM) on 11/18/2024 at 9:24 AM, the ADM stated ten (10) resident's rooms (Rooms 17, 42, 43, 44, 51, 52, 53. 54, 62 and 63) did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms. The ADM stated, the ADM will submit a room wavier for these resident rooms. During an observation on 11/18/2024 from 7:30 AM to 3:13 PM, Rooms 17, 42, 43, 44, 51, 52, 53, 54, 62 and 63 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to maneuver their wheelchairs easily and ambulated inside the rooms without difficulty. The nursing staff had enough space to provide care to the residents in the room. The rooms had space for beds, bedside tables, nightstands, and other medical equipment. During interview with residents residing in Rooms 17, 42, 43, 44, 51, 62, 53, 54, 62 and 63 both individually and collectively from 11/18/2024 to 11/21/2024, the residents did not express any concerns regarding the size of their rooms and stated they had enough space to move around freely. During interviews with nursing staff assigned to Rooms 17, 42, 43, 44, 51, 62, 53, 54, 62 and 63 from 11/18/2024 to 11/21/2024, the staff stated they were able to work and provide care to the residents in those rooms without issues/difficulty moving around. The staff stated there was enough space for them to provide care to residents and provide the residents with privacy and dignity. A review of the facility's submitted room waiver request letter indicated a request for the waiver to be granted on the condition that there was ample room to accommodate wheelchairs and other medical equipment, as well as space for mobility and movement of ambulatory residents. It also indicated that there was adequate space for nursing care, and the health and safety code of residents occupying these rooms were not in jeopardy. These rooms were in accordance and do not have an adverse effect on the resident's health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. During multiple observations made to rooms 17, 42, 43, 44, 51, 62, 53, 54, 62 and 63 from 11/18/2024 to 11/21/2024, the room sizes of the above rooms did not adversely affect the residents' health and or safety. The department is recommending approval of the room waiver submitted by the facility.

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F 0919

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure that a working call system is available in each resident's bathroom and bathing area.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46919

Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a resident to signal his or her need for assistance) was functioning to alert the staff that assistance was needed as for one (1) of 23 sampled residents (Resident 25).

This deficient practice had the potential to result in delay in meeting Resident 25's needs for hydration, toileting, and activities of daily living (ADL) which can lead to falls and/ or accidents.

Findings:

During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included epilepsy (a brain disorder that causes recurring , unprovoked episodes of abnormal electrical activity in the brain), personal history of transient ischemic attack (TIA- a brief stroke that occurs when blood flow to the brain is temporarily blocked) and cerebral infarction (a condition that occurs when blood flow to the brain is disrupted causing brain cells to die) without residual effects, and hypotension (low blood pressure).

During a review of Resident 25's History and Physical Examination (H&P), dated 6/4/2024, the H&P indicated Resident 25 had the capacity to understand and make decisions.

During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool), dated 8/30/2024, the MDS indicated Resident 25 was assessed to require substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, personal hygiene, and upper and lower body dressing. Resident 25 required supervision or touching assistance with sit to lying, sit to stand, and toilet transfer.

During a concurrent observation in Resident 25's room and interview with Resident 25 on 11/18/2024, at 8:49 AM, Resident 25's call light indicator on the wall did not turn on after Resident 25 pushed the call light button. Resident 25 stated she did not know how she can call for assistance since the call light was not functioning (resident unable to recall since when).

During the same observation and concurrent interview with Certified Nursing Assistant 8 (CNA 8), on 11/18/2024, at 8:49 AM, CNA 8 stated the call light indicator on the wall and above the door was supposed to light up when the resident pushes the call light button. CNA 8 pushed Resident 25's call light button and both call light indicators on the wall and outside Resident 25's room did not light up. CNA 8 stated, Resident 25's call light system was not working.

During an interview with the Maintenance Supervisor (MTS), on 11/18/2024, at 9:06 AM, the MTS stated Resident 25's call light was broken. MTS stated facility staff did not inform him that Resident 25's call light was broken.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA 1, on 11/19/2024, at 3:11 PM, CNA 1 stated residents use the call light when assistance is needed. CNA 1 stated if residents are not able to get assistance, they can have accidents on the bed or fall. CNA 1 stated the call light needs to be functional at all times. CNA 1 stated, broken call lights need to be reported to the Charge Nurse (CN) right away. During a follow up interview with the MTS, on 11/19/2024, at 3:30 PM, the MTS stated it was the facility staff's responsibility to report broken call lights in the facility. The MTS stated call lights in need of repair are logged in the Maintenance Communication book. The MTS stated the Maintenance Communication book was checked by the MTS daily. The MTS stated Resident 25's broken call light was not reported or logged in the Maintenance Communication book. The MTS stated it was important for residents to have a functioning call light to get the assistance they need especially during an emergency. During a review of the facility's policy and procedure (P&P), titled, Call System, Residents, revised on 9/2022, the P&P indicated the following: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. The resident call system is routinely maintained and tested by the maintenance department.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to provide a safe environment for one of 23 sampled residents (Resident 43) by: 1. Failing to ensure the designated exit door was not blocked by a wheelchair. This deficient practice had the potential for residents to be placed at risk for injury by not allowing a rapid evacuation in case of an emergency. 2. Failing to ensure the hallway for Resident 43 to pass through back and forth from the resident's room to the activity room was not cluttered with multiple parked wheelchairs and equipment (such as Hoyer lift [mechanical device that helps transfer people with limited mobility from one place to another. It allows a person to be lifted and transferred with a minimum of physical effort], walker and clean linen cart). This deficient practice placed Resident 43 at risk for accident, tripping, or fall. Findings: 1. During an observation of the facility, on 11/18/2024, at 10:54 AM, a wheelchair was observed in the middle of the hallway in front of the emergency exit doors. During an interview with the Activity Director (ACD), on 11/21/2024, at 9:30 AM, the ACD stated unused wheelchairs were placed in the hallways or in the residents' rooms. ACD stated wheelchairs should not be left in the middle of the hallway that leads to the emergency exit doors. ACD stated residents will not be able to immediately evacuate the facility if the emergency exit doors were blocked. ACD stated residents who walk around the facility can push the wheelchair and hit another resident if they see a wheelchair in the middle of the hallway. ACD stated all facility staff were responsible in ensuring the hallways leading to the emergency exit doors were clear for the residents' safety. During an interview with the Interim Director of Nursing (IDON), on 11/21/2024, at 9:41 AM, the IDON stated emergency exit doors should be clear for egress (action of going out of or leaving a place) and to allow emergency personnel to enter the facility during an emergency. The IDON stated wheelchairs were stored outside the residents' rooms or inside the room as long as the wheelchairs were not blocking the way. During a record review of the facility's policy and procedure (P&P), titled, Exit or Means of Egress, revised on 1/2019, the P&P indicated, All personnel shall keep exits clear at all times. Exit doors should never be blocked, even briefly. The P&P further indicated, Whoever discovers a blocked exit shall clear the exit, if possible, and report the finding to his or her Immediate Supervisor or to a supervisor or manager in the building if the Immediate Supervisor is not present. 48143 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Vista Care Center	909 W. Santa Anita Ave San Gabriel, CA 91776

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 43's Admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting left nondominant side. During a review of Resident 43's History and Physical (H&P), dated 5/22/2024, indicated Resident 43 has the capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS, a resident assessment tool), dated 9/6/2024, indicated it is very important for Resident 43 to do things with groups of people in the activity room, it is also important for her to go outside to get fresh air when the weather is good. During an interview on 11/19/2024 at 10:36 AM, Resident 43 stated there is a potential for the residents to get hit by the wheelchairs during the rush hours after morning and afternoon activities and all residents have to go back to their rooms for lunch or dinner. Resident 43 stated there were multiple wheelchairs and other equipment such as Hoyer lift, walker, and clean linen cart along the hallway which can cause residents to trip and fall. During an observation on 11/18/2024 at 9:44 AM in front of room [ROOM NUMBER], there were four wheelchairs and one gray trash bin along the hallway in front of room [ROOM NUMBER]. During an observation on 11/18/2024 at 12:25 PM in the hallway in between room [ROOM NUMBER] and room [ROOM NUMBER], there was one isolation cart, one linen cart, one front wheeled- walker and two wheelchairs. During a concurrent observation and interview on 11/21/2024 at 8:45 AM with Certified Nursing Assistant 7 (CNA7) in the hallway near room [ROOM NUMBER] and room [ROOM NUMBER], CNA7 stated the wheelchairs parked along the hallway will be used by the residents who were in the activity room, and it is a little packed. CNA7 stated trash bin, wheelchairs, and linen carts should be placed all in one side of the hallway only to avoid clutter in the hallway. During a concurrent observation and interview on 11/21/2024 at 8:41 AM with Licensed Vocational Nurse 5 (LVN5) in the hallway near room [ROOM NUMBER] and room [ROOM NUMBER], LVN5 stated all the wheelchairs and Hoyer lift have been in the hallway for a long time. LVN 5 stated there are also one gray bin which is used for soiled linen and a blue bin for other trash cluttered along the hallway. LVN5 that the facility staff should keep all the wheelchairs, equipment, and bins on one side of the hallway. During an interview on 11/21/2024 at 3:26 PM with Registered Nurse Supervisor 1 (RNS1), RNS1 stated linen carts, bins, wheelchairs have been in the hallway for a long time, this can be a potential issue for patient injury, tripping hazard and risk of fall. During a review of the facility's Policy and Procedure titled Safety and Supervision of Residents, revised July 2017, indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Royal Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 W. Santa Anita Ave San Gabriel, CA 91776	

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. b. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. c. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. d. When accident hazards are identified, the Quality Assurance and Performance Improvement (QAPI- a data-driven approach to improving the quality of care and services provided to patients), safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.