STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, and facility P&P review, the facility failed to properly obtain the informed consents (permission granted in the knowledge of the possible consequences) for the use of psychotropic medications (medications affecting brain activity) and treatments from the responsible party (person designated to make decisions on behalf of the residents) for one of five final sampled residents (Residents 64) reviewed for unnecessary medications. This failure posed the risk for Residents 64 and his responsible party to not be informed of Resident 64's medications and the potential side effects. Findings: According to AFL 24-7 titled Assembly [NAME] (AB) 48 - Nursing Facility Resident Informed Consent Protection Act of 2023 dated 2/28/24, with an effective date of 1/1/24, the facilities must obtain a resident's written informed consent for treatment using psychotherapeutic drugs, and must renew the written informed consent every six months. At that time, the facility must provide the resident with any recommended dosage adjustments and the option of revoking consent. If the resident decides to discontinue using the drug, the prescriber is responsible for planning any necessary, gradual dose reduction, as well as possible behavioral interventions. Review of the facility's P&P titled Informed Consent dated 3/25/24, showed each resident is informed of his/her total health status and medical conditions, including diagnosis, treatment recommendations and prognosis, in advance of treatment and on on-going basis. If a resident has an appointed representative, the representative is also informed. Medical record review for Resident 64 was initiated on 7/18/24. Resident 64 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 64's H&P examination dated 3/17/24, showed Resident 64 did not have the capacity to understand and make decisions. Review of Resident 64's physician's order showed an order dated 4/5/24, to administer Seroquel (antipsychotic medication) 100 mg at bedtime for psychosis (a mental disorder characterized by a disconnection from reality)manifested by striking out. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the form titled Physician Documentation of Informed Consent for the use of Seroquel medication dated 9/25/23, showed the informed consent was obtained more than six months prior to the new order of Seroquel dated 4/5/24. There was no documented evidence to show the informed consent for the use of antipsychotic medication was renewed and discussed with Resident 64's responsible party. On 7/18/24 at 1151 hours, an interview and concurrent medical record review for Resident 64 was conducted with LVN 5. LVN 5 verified there was no informed consent obtained for the use of Seroquel medication. On 7/18/24 at 1639 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified the findings. Cross reference to F758.

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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 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** 48853 Based on observation, interview, and medical record review, the facility failed to provide the reasonable accommodations to meet the needs two nonsampled residents (Residents 38 and 124) observed during the initial tour. * The facility failed to ensure Residents 38 and 124's call lights were within the residents' reach. This failure had the potential to negatively impact the residents' psychosocial well-being or result in a delay to receive care. Findings: 1. On 7/16/24 at 0837 hours, during the initial tour, Resident 124 was observed in bed with call light not within reach. The call light was observed clipped to the call light panel on the wall. Resident 124 complained of legs hurting. On 7/16/24 at 0844 hours, an interview with the IP was conducted. The IP verified the call light was clipped to the wall call light panel and not within Resident 124's reach. The IP stated Resident 124 was able to use call light. Medical record review for Resident 124 was initiated on 7/16/24. Resident 124 was admitted to the facility on [DATE]. Review of Resident 124's MDS assessment dated [DATE], Section B, showed Resident 124 was able to usually make self-understood and usually understands others. Review of Resident 124's H&P examination dated 7/19/24, showed the resident had the capacity to make decision. 39453 2.a. On 7/16/24 at 1020 hours, during the initial tour of the facility, Resident 38 was observed lying in bed. Resident 38's call light button was observed underneath his pillow and Resident 38 could not reach the call light cord. When asked about the call light, Resident 38 stated he sometimes used the call light to get help from the facility staff. On 7/16/24 at 1022 hours, an observation for Resident 38 and concurrent interview was conducted with CNA 3. Resident 38 was observed lying in bed. Resident 38's call light button was observed underneath his pillow and the call light was not within the resident's reach. CNA 3 verified the above findings. CNA 3 stated the physical therapist was working with Resident 38 earlier and must have forgotten to place the call light within the resident's reach when he was assisted back to bed. Medical record review for Resident 38 was initiated on 7/16/24. Resident 38 was readmitted to the facility on [DATE]. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 38's MDS dated [DATE], showed Resident 38 had a moderately impaired cognition, with no impairment to the upper and lower extremities, and needed moderate to maximal assistance with mobility. Review of Resident 38's MDS dated [DATE], showed Resident 38 had no impairment to the upper and lower extremities; and needed substantial/maximal assistance on eating, personal hygiene, and mobility, and dependent on toileting, bathing, and dressing. b. On 7/17/24 at 0830 hours, Resident 38 was observed lying in bed. Resident 38's call light button was observed underneath his pillow and Resident 38 could not reach the call light cord. When asked about the assistance he needed, Resident 38 stated he needed his bedside table moved and also requested for water. On 7/17/24 at 0833 hours, LVN 7 was asked to go inside Resident 38's room. Resident 38 was observed lying in bed, and his call light button was observed underneath his pillow. The call light was not within Resident 38' reach. LVN 7 verified the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to clearly identify the current code status to obtain a copy of an advance directive and provide the written information regarding the rights to formulate the advance directives for three of 26 final sampled residents (Residents 24, 48, and 99) reviewed for advance directives. * The facility failed to clarify and honor Resident 99's desire not to prolong life in case of incapacity. Resident 99's advance directive showed the resident did not wish to prolong life in case of incapacity, while Resident 99's POLST showed to attempt CPR. * The facility failed to ensure the copy of Resident 48's advance directive for healthcare was obtained and maintained in the resident's medical record. * The facility failed to ensure Resident 24 was offered information on how to formulate an advanced directive. These failures had the potential to not provide care in accordance with Resident 24, 48, and 99's treatment wishes. Findings: Review of the facility's P&P titled Advance Directives dated ,d+[DATE] showed the following: - The facility will provide written information to residents and/or their representative, should they desire, on formulation of an advance directive with respect to advance directives and applicable State law; - Upon admission or as soon as practicable thereafter, the resident and/or his/ her legal representative or surrogate decision maker will be provided with information regarding preferred intensity or care and/or advance directives; - If there is an advance directive or individual healthcare instruction(s) documented by a healthcare worker, then this information shall be placed in the clinical record when provided by the resident or their representative. This document will be filed in the resident's clinical record in a place that is easily accessible in the event of an emergency. 1. Medical record review for Resident 99 was initiated on [DATE]. Resident 99 was readmitted to the facility on [DATE]. Review of Resident 99's H&P examination dated [DATE], showed Resident 99 had the capacity to make medical decisions. Review of Resident 99's Advance Directives dated [DATE], showed Resident 99 did not wish to prolong her life in case of incapacity. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 99's POLST dated [DATE], showed Resident 99's code status was to attempt resuscitation/ CPR. The POLST, under Section D, was left blank and not completed to show Resident 99 had an advance directive. Review of Resident 99's Order Summary Report showed a physician's order dated [DATE], showing Resident 99 was a full code. On [DATE] at 1017 hours, an interview and concurrent medical record for Resident 99 was conducted with the SSD. The SSD verified the above findings. The SSD verified Resident 99's wish to not to prolong her life in case of incapacity per her advance directives, did not match Resident 99's POLST showing a full code status. The SSD stated the social services department and/or the nursing department had to ensure the POLST and advance directive matched. The SSD stated if the POLST and advance directive did not match, the social services department had to follow-up with the resident and/or his/ her representative, to make sure the resident's code status reflected the resident's wishes. When asked who responsible to update the resident's POLST to reflect the existence of Resident 99's advance directive, the SSD stated the social services department did not fill out nor update the POLST, and the nursing department would have to update it. 2. Medical record review for Resident 48 was initiated on [DATE]. Resident 48 was initially admitted to the facility [DATE]. Review of Resident 48's H&P examination dated [DATE], showed Resident 48 had the capacity to understand and make decision. Review of Resident 48's POLST dated [DATE], under Section D Information and Signatures, showed Resident 48 had capacity, and an advance directive was available and reviewed. However, review of Resident 48's medical record failed to show a copy of Resident 48's advance directive was obtained, or an attempt was made to obtain Resident 48's advance directive. On [DATE] at 0923 hours, an interview and concurrent medical record review for Resident 48 was conducted with RN 2. RN 2 verified the above findings. When asked about the advance directive, RN 2 stated the admitting nurse would ask the resident or any family member or representative about advance directive upon admission, and the nurse would complete Section D on the POLST to show whether the resident had an advance directive or not. When asked about following up for a copy of the advance directive, RN 2 stated any of the nurses would usually follow-up about the advance directive on the next day after admission. RN 2 verified Resident 48's POLST showed Resident 48 had an advance directive; however a copy of Resident 48's medical record was not available in the resident's medical record. RN 2 verified there was no documentation showing the nurses had followed up for a copy of Resident 48's advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0948 hours, an interview and concurrent medical record review for Resident 48 was conducted with the SSD. The SSD verified the above findings. The SSD stated the POLST and advance directive should be initiated upon admission and followed up the next day. The SSD stated the social services department followed up for the copy of the residents' advance directive. The SSD stated if a follow-up had been done, it would be documented in the baseline care plan or the progress notes. The SSD verified Resident 48's POLST showed Resident 48 had an advance directive; however a copy of Resident 48's medical record was not available in the resident's medical record. The SSD verified there was no documentation showing the social services department had followed up for a copy of Resident 48's advance directive. 50126 3. Medical record review for Resident 24 was initiated on [DATE]. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's POLST dated [DATE], showed Resident 24 had capacity to make decisions. In addition, the POLST showed Resident 24 did not have an advance directive. Review of Resident 24's H&P examination dated [DATE], showed the resident had the capacity to make decisions. On [DATE] at 1446 hours, an interview and concurrent medical record review for Resident 24 was conducted with the SSD. The SSD stated Resident 24 had a POLST dated [DATE], and the POLST did not show Resident 24 had an advanced directive. The SSD further stated the Advance Directive Acknowledgment Form was not signed indicating information about formulating an advanced directive was not given to Resident 24 or a family member. On [DATE] at 1115 hours, an interview was conducted with LVN 4. LVN 4 stated when the residents were admitted to the facility, the Social Services would meet with the resident and or family member and ask if the resident had an advanced directive or would provide information. LVN 4 verified Resident 24 did not have an advanced directive in the medical record. On [DATE] at 1145 hours, an interview was conducted with Resident 24. Resident 24 was asked if the facility staff offered information about, or assistance with formulating an advance directive. Resident 24 stated he did not receive information about, or assistance with formulating an advance directive.

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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** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive care plans to reflect the individual care needs for four of 26 final sampled residents (Residents 46, 116, 120, and 374). * The facility failed to develop a care plan problem to address Resident 116's left heel pressure injury. * The facility failed to develop a care plan to address Resident 120's need for fluid restriction and the use of ertapenem sodium injection solution (an antibiotic used to treat infections caused by bacteria) intravenously (into or by means of a vein or veins) for treatment of empyema of pleura (an infection that spreads directly from the lung that leads to a buildup of pus in the pleural space (thin space inside the chest wall). * The facility failed to develop a care plan problem to address Resident 46's left air pain and ear treatments. * The facility failed to develop a care plan problem to address droplet isolation precaution for Resident 374. These failures posed the risk of not providing the appropriate, consistent, and individualized care to the residents Findings: 1. Review of the facility's P&P titled Pressure Injury Prevention and Management reviewed April 2024 showed this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer or injury, prevent infection and the development of additional pressure ulcers or injuries. In interventions for prevention and promote healing section showed, a. after completing a thorough assessment or evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Medical record review for Resident 116 was initiated on 7/16/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's Order Summary Report for July 2024 showed a physician's order dated 7/6/24, to cleanse the left heel pressure injury with normal saline, wound cleanser, pat dry, apply Betadine solution (antiseptic) on affected area and leave open to air daily for 30 days. Review of Resident 116's plan of care failed to show a care plan problem was developed to address the care for the left heel pressure injury. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 1101 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the comprehensive care plan for Resident 116 failed to show a care plan was developed for the left heel pressure injury. Cross reference to F686, example #2. 2. Medical record review for Resident 120 was initiated on 7/16/24. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120's Order Summary Report for July 2024 showed a physician's order for the following: - on 7/4/24, fluid restriction 1,500 ml per day: Dietary 720 ml (breakfast 240 ml, lunch 240 ml, and dinner 240 ml) Nursing 780 ml (7 AM-7 PM shift for 400 ml and 7 PM-7 AM shift for 380 ml). - on 7/3/24, to administer ertapenem sodium injection solution 1 gm intravenously one time a day for 10 days for pneumonia. - on 7/16/24, to administer ertapenem sodium injection solution 1 gm intravenously one time a day for empyema of pleura until 7/19/24. Review of Resident 120's plan of care failed to show a care plan problem was developed for fluid restriction and the use of ertapenem sodium intravenously for treatment of pneumonia or empyema of pleura. On 7/19/24 at 1027 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the comprehensive care plan for Resident 120 did not address the fluid restriction and the use of ertapenem sodium intravenously for treatment of pneumonia or empyema of pleura for Resident 120. Cross reference to F692, example #2. 39453 3. On 7/16/24 at 0944 hours, during the initial tour of the facility, Resident 46 was observed in her wheelchair inside the room. Resident 46 stated she could not hear well and already informed the nurse about it. Medical record review for Resident 46 was initiated on 7/16/24. Resident 46 was admitted to the facility on [DATE]. Review of Resident 46's Internal Medicine H&P/Progress Note dated 6/28/24, showed Resident 46 had the capacity to make decisions. Review of Resident 46's Order Summary Report showed the physician's orders dated 7/16/24, for the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- To instill five drops of Debrox otic solution (medication used to treat earwax buildup) in the left ear two times a day for impacted cerumen for five days; and - To irrigate left ear with sterile water after the last treatment dose for impacted cerumen on 7/20/24. Review of Resident 46's plan of care failed to show a care plan problem to address the resident's hearing difficulty and ear treatments. On 7/18/24 at 1544 hours, an interview and concurrent medical record review for Resident 46 was conducted LVN 4. LVN 4 stated Resident 46 complained about not being able to hear on her left ear, and she was receiving eardrops and also due for a left ear irrigation in two days. LVN 4 verified there was no documented evidence a care plan problem was developed to address Resident 56's hearing difficulty and ear treatments. On 7/19/24 at 1553 hours, an interview and concurrent medical record review for Resident 46 was conducted with the DON. The DON verified there was no documented evidence a care plan problem was developed to address Resident 56's hearing difficulty and ear treatments. 4. On 7/16/24 at 0923, 1020, and 1146 hours, during the initial tour of the facility, the contact and droplet Isolation precaution signs were observed posted by the entrance of Resident 374's room. On 7/17/24 at 0824 and 0919 hours; 7/18/24 at 0750 and 1605 hours; and 7/19/24 at 1147 hours, a Droplet Isolation Precaution sign was observed posted by the entrance of Resident 374's room. Medical record review for Resident 374 was initiated on 7/16/24. Resident 374 was admitted to the facility on [DATE]. Review of Resident 374's Order Summary Report showed the following physician's orders dated: -7/8/24, for contact precautions for C. auris (Candida auris, a type of yeast that can cause a severe, often multi-drug resistant, infections); -7/8/24, for enhanced barrier precautions related to GT; -7/8/24, for enhanced barrier precautions related to wound care; and -7/17/24, for droplet precautions related to Acinetobacter species (a group of bacteria commonly found in soil and water). Review of Resident 374's plan of care showed a care plan problem addressing Resident 374's infection, and the interventions included to place Resident 374 under the enhanced barrier precautions. Further review of Resident 374's plan of care failed to show a care plan problem to address Resident 374's droplet isolation precautions. On 7/19/24 at 1553 hours, an interview and concurrent medical record review for Resident 374 was conducted with the DON. The DON verified there was no documented evidence a care plan problem was developed to address Resident 374's droplet isolation precautions.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview and medical record review, the facility failed to ensure the comprehensive plan of care was revised to reflect the resident's care needs for one of 26 final sampled residents (Resident 116). * The facility failed to ensure Resident 116 comprehensive care plan was revised to show the resident's current antibiotic medication and contact isolation precaution. This failure had the potential for not providing necessary care and services to meet the resident's needs. Findings: Medical record review for Resident 116 was initiated on 7/16/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's Order Summary Report for July 2024 showed a physician's order dated 7/14/24, to administer Levaquin (an antibiotic used to treat bacterial infections) 500 mg one tablet by mouth one time a day for UTI for seven days. Review of Resident 116's urine culture laboratory results dated [DATE], showed urine culture, >100,000 CFU/ml Proteus mirabilis (Proteus mirabilis is a common pathogen responsible for complicated UTI that sometimes causes bacteremia) ESBL. Further review of Resident 116's Order Summary showed no order for contact isolation for ESBL in urine Review of Resident 116's urine culture laboratory results dated [DATE], showed urine culture >100,000 CFU/ml Proteus mirabilis ESBL. Review of Resident 116's care plan initiated on 7/13/24, showed the resident was on antibiotic therapy (Cipro) oral tablet related to UTI. Further review of Resident 116's care plan failed to show a care plan problem for UTI was revised for the Levaquin ordered on 7/14/24, and a contact isolation initiated for the resident. On 7/16/24 at 0940 hours, during an initial tour, a contact precautions sign was observed by Resident 116's door informing everyone must clean their hands, including before entering and when leaving the room. The sign also showed the providers and staff must put on gloves before room entry and discard gloves before room exit; and put on gown before room entry and discard gown before room exit. On 7/16/24 at 0945 hours, an interview with LVN 7 was conducted. LVN 7 verified Resident 116 was on contact isolation for ESBL in urine. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	On 07/18/24 at 1411 hours, an interview and concurrent record review with LVN 7 was conducted. LVN 7 verified Resident 116 was on Levaquin for UTI. LVN 7 verified the care plan for Resident 116 was not revised to show the resident was on Levaquin instead of the Cipro antibiotic and to include the resident was placed on contact isolation. On 7/19/24 at 1520 hours, an interview with the DON was conducted. The DON was informed and acknowledged above findings.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility document review, the facility failed to provide the necessary ADL care and services for two of two residents (Residents 48 and 374) investigated for ADL care. * Resident 48 was provided with only two showers on 7/15 and 7/18/24, instead of twice a week since his admission on 7/1/24. * Resident 374 was provided with only one shower on 7/14/24, instead of twice a week since her admission on 7/6/24. These failures posed the risk of the residents not being provided with the appropriate care which could negatively impact their psychosocial well-being. Findings: 1. On 7/16/24 at 0857 hours, during the initial tour of the facility, Resident 48 was observed lying in bed. Resident 48 was observed wearing a gown, and his hair was unkempt. Resident 48 was observed not on any isolation precautions. Medical record review for Resident 48 was initiated on 7/16/24. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's H&P examination dated 7/3/24, showed Resident 48 had the capacity to understand and make decisions. Review of Resident 48's Order Summary Report showed the following physician's orders dated: - 7/2/24, to administer Amoxicillin (antibiotic medication) 500 mg one capsule by mouth two times a day for pneumonia. This order was discontinued on 7/2/24; -7/2/24, for contact isolation for Escherichia coli, Klebsiella pneumoniae, and ESBL in the sputum. This order was discontinued on 7/2/24, and the note showed, clarification of order. -7/2/24, for contact and droplet precautions related to pneumonia. This order was discontinued on 7/5/24, and the note showed, antibiotic treatment course is completed. -7/3/24, to administer Amoxicillin 500 mg by mouth two times a day for pneumonia. This order was discontinued on 7/15/24. -7/15/24, to administer Amoxicillin 500 mg by mouth two times a day for jaw necrosis (osteonecrosis of the jaw, a severe bone disease affecting the the maxilla and the mandible, which was a rare side effect of some drugs for osteoporosis and cancer). (continued on next page)

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Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Follow-Up Question Report (CNA documentation) showed Resident 48 received bed baths on 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/13, and 7/14/24; and a shower on 7/15/24. On 7/18/24 at 0813 hours, an interview was conducted with Resident 48. Resident 48 was observed in bed wearing a hospital gown. When asked about showers, Resident 48 stated he was provided with only one shower last Monday (7/15/24) since his admission on 7/1/24. Resident 48 stated the staff changed his gown and bed linen, but it would be nice to get showers. On 7/18/24 at 1121 hours, an interview and medical record review for Resident 48 was conducted with the DSD. The DSD stated she worked as the IP when Resident 48 was admitted . The DSD stated Resident 48 was scheduled to have showers every Monday and Thursday each week. The DSD stated if a resident refused showers, the CNAs were supposed to report to the LVN; and the LVN would document in the progress notes. The DSD verified Resident 48 received bed baths on 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/13, and 7/14/24; and a shower on 7/15/24. The DSD verified there was no documentation Resident 48 refused showers. The DSD stated Resident 48 was not provided showers but only bed bath because he was on contact and droplet precautions when he came. The DSD stated she had to clarify the physician's orders for the Amoxicillin medication and isolation precautions. When asked to show documentation of the follow-up calls to the physician, the DSD could not provide documentation in Resident 48 medical record. On 7/18/24 at 1402 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 48 did not refused showers, and she provided a shower to Resident 48 today. 2. On 7/16/24 at 0923, 1020, and 1146 hours, during the initial tour of the facility, the Contact and Droplet Isolation Precaution signs were observed posted by the entrance of Resident 374's room. On 7/17/24 at 0824 and 0919 hours, 7/18/24 at 0750 and 1605 hours, and 7/19/24 at 1147 hours, a Droplet Isolation Precaution sign was observed posted by the entrance of Resident 374's room. Medical record review for Resident 374 was initiated on 7/16/24. Resident 374 was admitted to the facility on [DATE]. Review of Resident 374's H&P examination dated 7/9/24, showed Resident 374 was able to make medical decisions by herself. Review of Resident 374's Order Summary Report showed the following physician's orders dated: -7/8/24, for Contact Precautions for C. auris; -7/8/24, for Enhanced Barrier Precautions related to GT; -7/8/24, for Enhanced Barrier Precautions related to wound care; and -7/17/24, For Droplet Precautions related to Acinetobacter species. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Follow-Up Question Report (CNA documentation) showed Resident 374 received bed baths on 7/6, 7/7. 7/9, 7/10, 7/11, 7/12, 7/13, 7/15, 7/16, 7/17, 7/18, and 7/19/24; and a shower on 7/14/24. The report also showed Resident 374 had refused bathing on 7/8/24. On 7/19/24 at 1119 hours, an interview and concurrent medical record review for Resident 374 was conducted with the IP. The IP stated a resident on isolation could be given showers or take showers but the resident had to wear a mask, and would have to be the last resident to use the shower room. On 7/19/24 at 1146 hours, an interview was conducted with CNA 3. When asked about providing showers to Resident 374, CNA 3 stated Resident 48 was scheduled to have showers every Monday and Thursday each week; however, they did not provide showers for the residents on droplet precautions such as Resident 374. CNA 3 stated only bed baths were provided to the residents on a droplet precautions. On 7/19/24 at 1147 hours, an interview was conducted with Resident 374. Resident 374 was observed in bed wearing a hospital gown. When asked about showers, Resident 374 stated, I would like to get a shower. I have never been given one. A shower would surely feels nice. Resident 374 stated she did not refused shower on 7/8/24, and was not given a shower on 7/14/24. On 7/19/24 at 1406 hours, an interview and concurrent medical record review for Residents 48 and 374 was conducted with the DON. The DON stated a resident on isolation could be provided with showers provided the staff and resident adhered to isolation protocols such as the resident had to wear a mask, the resident was the last one to get a shower, and the housekeeping had to clean the shower room after. The DON verified Residents 48 and 374 were not provided their scheduled showers.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of new pressure injury (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) and promote healing of existing pressure ulcer for two of three sampled residents (Residents 103 and 116) reviewed for pressure injury. * The facility failed to ensure Resident 103's wound care was provided in a manner to decrease infection and cross contamination as per the facility's P&P. * The facility failed to ensure Resident 116's bilateral lower extremities were offloaded as per the physician's order. These failures had the potential for deterioration of wound and delay of wound healing for these residents. Findings: 1. Review of the facility's P&P titled Clean Dressing Change revised on April 2024 showed it is the policy of this facility to provide wound care in a manner to decrease potential for infection and or cross contamination. In the policy explanation and compliance guidelines section, it showed to place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites. Review of Resident 103's Order Summary for July 2024 showed the following physician's orders dated: - 7/9/24, to cleanse the sacrococcyx (lower back and tail bone area) pressure injury with normal saline (mixture of sodium chloride and water to cleanse wound), apply Bactroban 2% ointment (topical antibiotic) followed by gentamicin cream 0.1% (topical antibiotic) on affected site, and cover with a dry dressing daily and whenever necessary if wet or dislodged for 14 days; and - 7/9/24, for contact isolation for sacrococcyx pressure injury with MRSA. On 7/18/24 at 1005 hours, a wound care observation for Resident 103 with LVN 3 and the IP was conducted. LVN 3 removed the old dressing from the sacrococcyx area saturated with yellowish exudate and leaked through the diaper. LVN 3 was observed cleansing the wound bed exposed to the diaper with the yellowish exudate. LVN 3 proceeded to wash his hands while the IP was holding the resident turned to the right-side, part of the sacrococcyx pressure injury wound bed was observed touching the soiled diaper with the yellowish exudate. LVN 3 was going to proceed with applying the antibiotic ointment. LVN 3 was asked to cleanse the wound again before application of the prescribed ointment and cream to prevent infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 1110 hours, an interview with LVN 3 was conducted. LVN 3 verified Resident 103's sacrococcyx pressure injury had exudate on the soiled dressing and diaper. LVN 3 verified he did not fold the diaper to prevent the wound bed from touching the soiled diaper. LVN 3 stated he did not usually use protective pads or barrier cloths when providing treatments to the residents. On 7/19/24 at 1515 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Pressure Injury Prevention and Management revised April 2024 showed this facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer or injury, prevent infection and the development of additional pressure ulcers or injuries. In the interventions for prevention and promote healing section showed c. Evidenced-based interventions for prevention will be implemented for all residents who are assessed at risk or who have pressure sore injury present. Basic or routine care interventions could include, but not limited to: I. Redistribute pressure (such as repositioning, protecting and or offloading heels). Medical record review for Resident 116 was initiated on 7/16/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's Order Summary Report for July 2024 showed an order on 7/6/24, for the bilateral lower extremities: to offload and elevate extremities with pillows or assistive devices every shift for skin maintenance and integrity every shift for 30 days. Review of Resident 116's plan of care failed to show a care plan problem was developed to address the care of the left heel pressure injury. On 7/18/24 at 0804 hours, Resident 116 was observed in bed lying on the back. On 7/18/24 at 0848 hours, an observation of Resident 116 with LVN 7 was conducted. Resident 116 was observed with legs elevated on pillow; however, the resident's heels were resting on the mattress. On 7/18/24 at 0852 hours, an interview with LVN 7 was conducted. LVN 7 verified Resident 116's heels were resting on the mattress. LVN 7 stated Resident 116's feet should be elevated to offload the heels from pressure. On 7/18/24 at 1608 hours, an observation of Resident 116 with CNA 12 was conducted. Resident 116 was observed with the resident's heels resting on the mattress. On 7/18/24 at 1609 hours, an interview with CNA 12 was conducted. CNA 12 verified Resident 116's heels were touching the mattress. On 7/19/24 at 1518 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to ensure two of five residents (Residents 48 and 120) reviewed for nutrition and hydration status maintained their acceptable nutritional and hydration status. * The facility failed to follow the RD's recommendations to provide two Boost VHC (a very high calorie complete nutritional drink which provides 530 calories per eight fluid ounce serving, with 22 grams of protein and 26 vitamins and minerals) every meals and to discontinue health shakes. In addition, the facility to clarify the physician's order whether to provide Boost VHC TID (three times a day) or with meals. * The facility failed to monitor Resident 120's fluid intake while on fluid restriction to assess and maintain proper hydration. These failures had the potential to compromise Resident 48's nutritional status, and Resident 120's hydration status and posed the risk for negative health outcomes. Findings: 1. On 7/16/24 at 0857 hours, during the initial tour of the facility, Resident 48 was observed in bed. Two bags containing cartons of regular Boost were observed at bedside. When asked about his meals, Resident 48 stated he was on a full liquid diet, and the facility usually gave him one carton of Boost each meal. On 7/16/24 at 1213 hours, during the initial dining observation, Resident 48 was observed in bed. A lunch tray containing one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice, and a cup of water. Review of Resident 48's meal ticket showed Resident 48 was on a full liquid diet. Resident 48 stated he was on a full liquid diet because of his difficulty with swallowing. Resident 48 stated he felt tired and did not have the energy. Resident 48 felt that he was losing weight and stated he may not be able to do his rehabilitation treatments. Medical record review for Resident 48 was initiated on 7/16/24. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's H&P examination dated 7/3/24, showed Resident 48 had the capacity to understand and make decisions. Review of Resident 48's Order Summary Report showed the following physician's orders dated: -7/11/24, to provide health shake with meals. This order was discontinued on 7/17/24; -7/11/24, to provide Boost VHC with meals. This order was discontinued on 7/17/24; and -7/17/24, to provide Boost VHC after meals. Vanilla flavor if/ when available. Provide two Boost VHC with meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 48's plan of care showed a care plan problem to address Resident 48's risk for weight loss, nutrition, hydration, and skin integrity complication related to altered diet. Review of Resident 48's Nutritional Assessment - V5 dated 7/2/24, showed Resident 48's estimated nutritional needs were 1480 to 1775 kcal calories, and 60 to 70 grams of protein. On 7/17/24 at 1230 hours, Resident 48 was observed in bed. A lunch tray containing one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice, and a cup of water. On 7/18/24 at 0800 hours, an interview for Resident 48 was conducted with CNA 4. When asked about Resident 48's meals, CNA 4 stated Resident 48 was on a liquid diet, and he drank most of it. CNA 4 stated Resident 48 usually would have one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice and a cup of water. On 7/18/24 at 0806 hours, CNA 4 was observed delivering Resident 48's breakfast tray. The breakfast tray was observed containing one carton of Boost VHC, one carton of health shake, one carton of milk, a cup of apple juice and a cup of water. On 7/18/24 at 1257 hours, an interview and concurrent medical record review was conducted with the RD. The RD stated she recommended two Boost VHC per meals which should be able to meet Resident 48's recommended caloric and protein intake. The RD stated she sent her recommendations in a word document via email to the Administrator, DON, and licensed nurses. Review of the RD recommendations dated 7/15/24, showed the following: - Change Boost VHC to Boost VHC TID (three times a day), vanilla flavor if/when available; - Provide two Boost VHC with meals per the resident request; and - Discontinue house shakes. On 7/18/24 at 1258 hours, Resident 48 was observed in bed. A lunch tray containing a carton of Boost VHC, a carton of vanilla health shake, a cup of water, and a cup of cranberry juice was observed at bedside. On 7/18/24 at 1402 hours, CNA 4 verified Resident 48 was served with a carton of Boost VHC, a carton of vanilla health shake, a cup of water, and a cup of cranberry juice. On 7/19/24 at 0811 hours, Resident 48 was observed in bed. A breakfast tray containing a carton of Boost VHC, two cartons of vanilla health shake, a cup of water, and one cup of cranberry juice was observed at bedside. A carton of a regular Boost was observed on the tray. Resident 48 stated he wanted two cartons of Boost VHC but was only served one, so Resident 48 drank a carton of regular Boost to add to the Boost VHC given by the facility. On 7/19/24 at 0812 hours, an observation for Resident 48 and concurrent interview was conducted with Dietary Aide 2. Dietary Aide 2 stated he was the team lead when the RD and DSS were not available. Dietary Aide 2 verified Resident 48 was served with a carton of Boost VHC, two cartons of vanilla health shake, a cup of water, and one cup of cranberry juice. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 1353 hours, an interview and concurrent medical record review for Resident 48 was conducted with the DON. The DON verified the RD recommended to change Boost VHC to Boost VHC TID, vanilla flavor if/when available, to provide two Boost VHC with meals per the resident request; and to discontinue house shakes. The DON stated the licensed nurses had to carry out the orders and follow the RD recommendations, and then the DSS should verify the orders were followed by the dietary staff as well. When asked if the RD recommendations to change Boost VHC to Boost VHC TID and to provide two Boost VHC with meals were clarified to show Boost VHC was provided three times a day (0900, 1300, and 1700 meals) and/or with meals (breakfast, lunch, or dinner), the DON did not find documentation to show the RD recommendations were clarified. 48853 2. Medical record review for Resident 120 was initiated on 7/16/24. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120's Order Summary Report for July 2024 showed a physician's order dated 7/4/24, for fluid restriction 1,500 ml per day: Dietary 720 ml (breakfast 240 ml, lunch 240 ml, and dinner 240 ml) and Nursing 780 ml (7 AM-7 PM shift for 400 ml and 7 PM-7 AM shift for 380 ml). Review of Resident 120's plan of care failed to show a care plan problem addressing the resident's fluid restriction. Review of the laboratory report for Resident 120 dated 7/15/24, showed the blood urea nitrogen (BUN) was 20 mg/dl (normal range: 7-17 mg/dl). Review of the Task Monitor Fluid Intake Follow Up Question Report for 7/1/24 to 7/19/24, showed the following: - 7/18/24 at 1356 hours, fluid intake was 720 ml; and - 7/18/24 at 1911 hours, fluid intake was 253 ml. On 7/18/24 at 1100 hours, an interview with CNA 13 was conducted. CNA 13 stated she was not sure if Resident 120 was on fluid restriction and if fluid intake was being monitored and need to be documented. On 7/19/24 at 1027 hours, an interview and concurrent record review was conducted with RN 2. RN 2 verified no monitoring of Resident 120's intake was done until 7/18/24 at 1356 hours. On 7/19/24 at 1530 hours, an interview with the DON was conducted. The DON verified the findings and stated the intake and output for Resident 120 were not monitored. Cross reference to F656, example #2.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility's P&P review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for one nonsampled residents (Resident 97). In addition, the facility failed to ensure the PICC line external catheter and arm circumference measurements were performed and documented in the medical record. These failures had the potential to delay the identification of catheter related complications for the residents. Findings: Review of the facility's P&P titled Central Venous Catheter Dressing Change dated 6/18 showed an assessment of the venous access site and dressing change should be performed upon admission and every seven days, and as needed; and assess the site for complications and notify the physician if problem exist. On 7/16/24 at 0830 hours, Resident 97 was observed with a PICC line on the right upper arm with a labeled transparent dressing. Medical record review for Resident 97 was initiated on 7/17/24. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's Order Summary report dated 7/18/24, showed a physician's orders dated 6/27/24, for the PICC line as follows: - To measure PICC line external catheter length and measure arm circumference upon admission and every seven days, and as needed for site maintenance. - To change the PICC transparent dressing per sterile technique upon admission and as needed every seven days for site maintenance. - To monitor the PICC line site for signs of inflammation every shift. Review of Resident 97's IV Administration Report for July 2024 showed the resident had a PICC line catheter. However, the medical record failed to show the length of the external catheter and arm circumference above the insertion site were obtained upon admission. On 7/18/24 at 1132 hours, an interview and concurrent medical record review for Residents 97 was conducted with RN 2. RN 2 verified Residents 97's medical record did not show the PICC line external catheter and arm circumference measurements. RN 2 stated the PICC line external catheter and resident's arm circumference measurements had to be done upon admission and with every dressing change. On 7/18/24 at 1636 hours, an interview and concurrent medical record review for Residents 97 was conducted with the DON. The DON verified the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to provide the necessary respiratory care for three of three sampled residents (Residents 54, 95, and 374) investigated for respiratory care. * The facility failed to ensure Resident 374's Yankauer suction (an oral suctioning tool used in medical procedures) was stored in a set-up bag when not in use. In addition, the facility failed to ensure Resident 374's oxygen saturation levels and administration of oxygen were documented in the MAR. * The facility failed to ensure Resident 95's oxygen saturation levels and administration of oxygen were documented in the MAR. * The facility failed to ensure Resident 54's nasal cannula tubing was stored in a set up bag when not in use and the nasal canula was observed on the floor and Resident 54's bed. In addition, the facility failed to ensure the administration of oxygen therapy for Resident 54 was documented and followed the physician's order. These failures posed the risk for cross contamination and negatively affect the residents's medical conditions. Findings: 1. On 7/16/24 at 1146 hours, during the initial tour of the facility, Resident 374 was observed in bed. Resident 374 was observed receiving oxygen at two liters per minute via nasal cannula. The nasal cannula tubing was dated 7/15/24. A Yankauer suction was observed inside an opened drawer of the bedside table and was not stored in a bag. The Yankauer suction was observed without a date. There were no set-up bags observed for the nasal cannula and Yankauer suction. Resident 374 stated the Yankauer suction was used once. Resident 374 also stated she was not sure why she had an oxygen on when she did not have any shortness of breath. Medical record review for Resident 374 was initiated on 7/16/24. Resident 374 was admitted to the facility on [DATE]. Review of Resident 374's H&P examination dated 7/9/24, showed Resident 374 was able to make medical decisions by herself. Review of Resident 374's Order Summary Report showed the following physician's orders dated: - 7/6/24, to provide oxygen via nasal cannula at two liters per minute, may titrate oxygen to maintain oxygen saturation level greater or equal to 92%, as needed for oxygen saturation management; and - 7/16/24, may suction as needed for increase secretions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 374's MAR for July 2024 did not show any documentation of oxygen saturation level and oxygen administration for Resident 374. Review of Resident 374's Weights and Vitals Summary showed Resident 374's oxygen saturation level ranged from 97% to 100% on room air from 7/6/24 at 1343 hours, to 7/18/24 at 1356 hours. On 7/17/24 at 0919 hours, and 7/18/24 at 1605 hours, Resident 374 was observed in bed. Resident 374 was observed receiving oxygen at two liters per minute via nasal cannula. The nasal cannula tubing was dated 7/15/24. A Yankauer suction was observed inside an opened drawer of the bedside table and was not stored in a bag. The Yankauer suction was not observed dated. There were no set-up bags observed for the nasal cannula and Yankauer suction. On 7/18/24 at 1606 hours, an observation for Resident 374 and concurrent interview and medical record review was conducted with LVN 7. Resident 374 was observed in bed. Resident 374 was observed receiving oxygen at two liters per minute via nasal cannula. The nasal cannula tubing was dated 7/15/24. A Yankauer suction was observed inside an opened drawer of the bedside table and was not stored in a bag. The Yankauer suction was not observed dated. There were no set-up bags observed for the nasal cannula and Yankauer suction. LVN 7 verified the above findings. LVN 7 stated Resident 374 had been on oxygen since admission. When asked about the documentation of Resident 374's oxygen saturation level and oxygen administration, LVN 7 verified it was not documented in Resident 374's MAR. 2. On 7/16/24 at 0914, 0922, and 1022 hours, 7/17/24 at 0640 hours, 7/18/24 at 0741 hours, and 7/19/24 at 0932 hours, Resident 95 was observed in bed receiving oxygen at two liters per minute via nasal cannula. Medical record review for Resident 95 was initiated on 7/16/24. Resident 95 was readmitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 11/8/23, showed Resident 95 had the capacity to understand and make decisions. Review of Resident 95's Order Summary Report showed a physician's order dated 6/26/24, to administer oxygen via nasal cannula at two liters per minute, may titrate oxygen to keep oxygen saturation level above 92% as needed for shortness of breath. Review of Resident 95's MAR for July 2024 did not show any documentation of the resident's oxygen saturation level and oxygen administration for Resident 95. Review of Resident 95's Weights and Vitals Summary showed Resident 374's oxygen saturation levels ranged from 98% to 99% on room air from 7/1, 7/3, 7/4, 7/7, 7/10, 7/11, 7/12, 7/13, 7/14, 7/18, and 7/19/24. On 7/19/24 at 0933 hours, an interview and concurrent medical record review for Residents 95 was conducted with RN 2. When asked about the documentation of Resident 95's oxygen saturation level and oxygen administration, RN 2 verified they were not documented in Resident 95's MAR. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 0948 hours, an observation for Resident 95 and concurrent interview was conducted with RN 2. Resident 95 was observed in bed receiving oxygen at two liters per minute via nasal cannula. RN 2 verified the above findings. On 7/19/24 at 1119 hours, an interview and concurrent medical record review for Residents 95 and 374 was conducted with the IP. The IP stated the Yankauer suction and oxygen nasal cannula should be labeled and dated, changed weekly, and stored in a set-up bag when not in use. On 7/19/24 at 1410 hours, an interview and concurrent medical record review for Residents 95 and 374 was conducted with the DON. The DON verified the above findings. The DON stated the oxygen saturation level and oxygen administration should have been documented in the residents' MAR. 39670 3. Medical record review for Resident 54 was initiated on 7/17/24. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's H&P examination dated 7/1/24, showed Resident 54 had no capacity to make medical decisions. a. On 7/16/24 at 0804 hours, during the initial tour of the facility, Resident 54 was observed in bed with the oxygen concentrator on at two liters per minute. A nasal cannula was connected from the oxygen concentrator and the nasal cannula was observed on the bed with part of the tubing on the floor. On 7/18/24 at 0804 hours, an observation and concurrent interview for Resident 54 was conducted with LVN 6. Resident 54 was in bed asleep and with an oxygen on via nasal canula which was attached to the oxygen concentrator setting at two liters per minute. The part of the nasal canula tubing was observed on the floor. LVN 6 verified Resident 54's use of oxygen therapy and the nasal canula tubing was observed in the floor. LVN 6 stated the nasal canula tubing should not be on the floor and should be placed inside the respiratory bag. b. Review of Resident 54's Order Summary Report dated 7/18/24, showed a physician's order dated 7/10/24, to administer oxygen via nasal canula at two liters per minute, may titrate oxygen to maintain the oxygen saturation level greater or equal to 96 percent, as needed for shortness of breath. Review of Resident 54's MAR for July 2024 showed the physician's order for oxygen therapy. However, further review of the document failed to show Resident 54's oxygen saturation levels and there was no licensed nurse's initial showing the administration of oxygen therapy to Resident 54. On 7/18/24 at 1132 hours, an interview and concurrent medical record review for Resident 54 was conducted with RN 2. RN 2 verified Resident 54's physician's order for the use of the oxygen. RN 2 was able to show the physician's order for oxygen was in the MAR. RN 2 verified there were no oxygen saturation levels documented when Resident 54 received an oxygen therapy. RN 2 stated the licensed nurse should have documented the oxygen saturation levels and administration of oxygen therapy to Resident 54. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 1640 hours, an interview and concurrent medical record review for Resident 54 was conducted with the DON. The DON was informed and verified the above findings.

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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. 48882 Based on interview, medical record review, and facility P&P, the facility failed to ensure the accurate documentation of two controlled medications on the Controlled Drug Record for one nonsampled resident (Resident 724). This failure had the potential for medication diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) of controlled medications. Findings: Review of the facility's P&P titled Controlled Medications dated 8/2024 showed when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and MAR: 1. Date and time of administration. 2. Amount administered. 3. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. 4. Initials of the nurse administering the dose on the MAR after the medication is administered. Review of Resident 724's MAR for June 2024 showed Resident 724 was administered the following controlled medications: - morphine sulfate (narcotic pain medication) IR 15 mg 1/2 tablet (half tablet) by mouth every four hours as needed for pain or shortness of breath on 6/20/24 at 1208 and 1738 hours, - lorazepam (antianxiety medication) 0.5 mg one tablet by mouth every six hours as needed for anxiety or shortness of breath on 6/20/24 at 1209 hours. Review of Resident 724's Narcotic and Controlled Substances Count Sheet for June 2024 for morphine sulfate IR 15 mg showed on 6/20/24 at 1208 and 1738 hours, a dose of morphine sulfate IR 15 mg 1/2 tablet was removed. However, Residents 724's Narcotic and Controlled Substances Count Sheet failed to show a licensed nurse's signature for the removal of the 1/2 tablet morphine sulfate IR 15 mg on 6/20/24 at 1208 and 1738 hours. Review of Resident 724's Narcotic and Controlled Substances Count Sheet for June 2024 for lorazepam 0.5 mg, showed on 6/20/24 at 1209 hours, a dose of lorazepam 0.5 mg one tablet was removed. However, Residents 724's Narcotic and Controlled Substances Count Sheet failed to show a licensed nurse's signature for the removal of the one tablet of lorazepam 0.5 mg on 6/20/24 at 1209 hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 1540 hours, an interview and concurrent review of the Narcotics and Controlled Substances Count Sheets for morphine sulfate IR 15 mg and lorazepam 0.5 mg for Resident 725 was conducted with the DON. The DON verified the above findings. The DON was asked about her expectations of the staff for removal of the narcotics and controlled drugs for administration. The DON stated the nurse was expected to record and sign on the count sheet after removal of the controlled drugs. On 7/18/24 at 1647 hours, the DON and Administrator were informed and acknowledged the findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, facility P&P review, and facility document review, the facility failed to ensure one of five sampled residents (Residents 64) reviewed for unnecessary medications was free from the unnecessary psychotropic medications (any medication which may affect brain activity associated with mental processes and behavior). * The facility failed to ensure Resident 64's monthly behavior summary was completed for the use of Seroquel (a medication used to treat schizophrenia), and sertraline (a medication used to treat depression). In addition, the facility failed to ensure the behavior manifestation and side effects for the use of antipsychotic medications were monitored. These failures had the potential to place the residents at risk for receiving unnecessary medications and increased risk of serious adverse reactions from the medications. Findings: Review of the FDA black box warning for prescribing quetiapine fumarate showed elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine fumarate is not approved for elderly patients with dementia-related psychosis. Review of the facility's P&P titled Psychotropic Medication revised on 11/2021 showed a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. The facility's P&P further showed the resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. The non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation. Furthermore, the facility's P&P showed residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs. Medical record review for Resident 64 was initiated on 7/18/24. Resident 64 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 64's H&P examination dated 3/17/24, showed Resident 64 did not have the capacity to understand and make decisions. Review of Resident 64's Order Summary Report dated 3/19/24, showed the following physician's orders: -an order dated 3/15/24, for Ativan 1 mg via GT every 12 hours as needed for anxiety manifested by inability to relax for 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-an order dated 3/18/24, for sertraline 50 mg via GT at bedtime for depression manifested by little interest in doing things. -an order dated 4/5/24, for Seroquel 100 mg at bedtime for psychosis manifested by striking out. Review of Resident 64's medical record showed the Psychotropic Summary Sheet for the summary of target behavior for the use of Seroquel and sertraline were last completed in June 2024. There was no summary of the target behaviors documented for the previous months. Further review of Resident 54's medical record failed to show documented evidence the behavior manifestation and side effects were monitored related to the use of Seroquel, sertraline, and Ativan medications. On 7/18/24 at 1151 hours, an interview and concurrent medical record review for Resident 64 was conducted with LVN 5. LVN 5 stated the behavior of Resident 64 was monitored every shift and documented in the medical record. LVN 5 verified there was no monitoring of the behaviors and side effects for the use of Seroquel, sertraline, and Ativan medication. Also, LVN 5 verified there was no behavior summary for the past previous months for the use of antipsychotic medications. On 7/18/24 at 1209 hours, an interview and concurrent medical record review for Resident 64 was conducted with the ADON. The ADON verified the above findings. The ADON stated she started to put the summary of the monitoring of the behaviors for the month of June. On 7/18/24 at 1639 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified the findings. Cross reference to F552.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 16%. One of four licensed nurses observed (LVN 6), was found to have made errors during the medication administration observation. * LVN 6 failed to ensure Resident 10's HR was taken prior to administering the metoprolol (blood pressure medication) and failed to administer the medications as per the physician's order. These failures had the potential to negatively affect Resident 10's health. Findings: Review of the facility's P&P titled Medication Administration- General Guidelines dated 10/2017 under the section Administration showed medications are administered in accordance with written orders of the attending physician; medications are administered within 60 minutes of scheduled time (one hour before and one hour after); except before or after meal orders, which are administered based on meal times. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility. On 7/18/24 at 0905 hours, a medication administration observation for Resident 10 was conducted with LVN 6. LVN 6 prepared and administered the following medications to Resident 10: - one tablet of ferrous sulfate (iron supplement) 325 mg, - one tablet of vitamin C (supplement) 500 mg, - one tablet of metformin hcl (antidiabetic medication) 1000 mg, - one capsule of dimethyl fumarate (for multiple sclerosis) delayed release 240 mg, - one tablet of Januvia (antidiabetic medication) 100 mg, - one capsule of lactobacillus (probiotic), - one tablet of magnesium oxide (supplement) 400 mg, - one tablet of metoprolol (antihypertensive medication) 75 mg, - two tablets of sennosides-docusate (stimulant laxative) 8.6 mg-50 mg, - one capful of polyethylene glycol (laxative) powder, 17 gm, - one soft gel capsule of coenzyme Q10 (supplement) 300 mg, - one tablet of multivitamins with minerals (supplement), and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- two sprays in each nostril of fluticasone nasal spray (corticosteroid), 50 mcg. Medical record review for Resident 10 was initiated on 7/18/24. Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE]. * Review of Resident 10's Order Summary Report for July 2024 showed a physician's order dated 2/11/24, to administer two capsules of Colace (stool softener) 100 mg two times a day for bowel management, to hold for loose stools. However, LVN 6 was observed not administering the Colace to Resident 10 during the medication administration observation. * Review of Resident 10's Order Summary Report showed a physician's order dated 2/11/24, to administer one tablet of metoprolol tartrate two times a day for hypertension (high blood pressure), to hold if SBP less than 110 mmHg or HR less than 60 beats per minute. However, LVN 6 was not observed obtaining Resident 10's HR prior to administering the metoprolol. * Further review of Resident 10's Order Summary Report showed the following physician's order: - dated 2/11/24, to administer one tablet of FerouSul (supplement) 325 mg one time a day for anemia, to take with breakfast, - dated 7/15/24, to administer one tablet of metformin hcl 1000 mg with meals for diabetes mellitus. However, LVN 6 was observed not administering the above medications to Resident 10 with meals. On 7/18/24 at 0945 hours, an interview was conducted with LVN 6. LVN 6 verified he did not check Resident 10's HR prior to administering the metoprolol to Resident 10. On 7/18/24 at 0955 hours, a follow up interview was conducted with LVN 6. LVN 6 verified he did not administer metformin and ferrous sulfate with meals as prescribed by the physician; and he did not administer Colace 100 mg to Resident 10 during the medication administration observation. On 7/18/24 at 1540 hours, the DON was informed and acknowledged the above findings. The DON stated the medications should be administered as ordered by the physician. The DON further stated she expected staff to follow the parameters as ordered for the medication administration and there may be the potential risk of negative resident outcomes if the physician's orders were not followed.

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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** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 10) was free from a significant medication error. *The facility failed to ensure Resident 10's HR was taken prior to administering the metoprolol (blood pressure medication). This failure had the potential to cause Resident 10 to have abnormally slow heart rate and negatively affect the resident's health. Findings: Review of the facility's P&P titled Medication Administration- General Guidelines dated 10/2017, under the section Administration showed medications are administered in accordance with written orders of the attending physician. On 7/18/24 at 0905 hours, a medication administration observation for Resident 10 was conducted with LVN 6. LVN 6 prepared and administered Resident 10's medications including one tablet of metoprolol 75 mg. LVN 6 was observed not obtaining Resident 10's HR prior to administering the metoprolol. Medical record review for Resident 10 was initiated on 7/18/24. Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 10's Order Summary Report for July showed a physician's order dated 2/11/24, to administer one tablet of metoprolol tartrate 75 mg two times a day for hypertension. The physician's order showed to hold the metoprolol if SBP less than 110 mmHg or if HR less than 60 beats per minute. On 7/18/24 at 0945 hours, an interview was conducted with LVN 6. LVN 6 verified he did not check Resident 10's HR prior to administering the metoprolol to Resident 10. On 7/18/24 at 1540 hours, the DON was informed and acknowledged the above findings. The DON stated the medications should be administered as ordered by the physician and the staff were expected to follow the parameters as ordered for medication administration. The DON stated for the blood pressure medication with parameters to hold, she expected the staff to obtain the heart rate and blood pressure prior to administration of the ordered medication. The DON further stated the potential risk of administration of the blood pressure medications without obtaining the heart rate was the potential for the heart rate to drop too low and cause negative outcome to the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the residents' medications were stored and labeled properly when: * The facility failed to ensure a multi-dose vial for one nonsampled resident (Resident 39) was labeled with the opened date in Medication Room B. This failure posed the potential risk of residents receiving expired medication. * The facility failed to ensure the medications for the discharged residents (Residents 115, 726, and 727) were placed in the designated location for medication destruction in Medication Room A. This failure have the potential for medications to be accidentally administered to residents. * The facility failed to ensure the discontinued medication for one nonsampled resident (Resident 45) was removed from the medication cart; failed to ensure the external medication was kept separate from the orally administered medications; and failed to ensure the inhalation solution vials for one nonsampled resident (Resident 728) were stored and discarded as per the manufacturer label, in Medication Cart A. These failures have the potential for medication to be accidentally administered, cross-contamination of the medications, and potential to alter the efficacy of the medication. * The facility failed to ensure the topical medications were labeled with the open date for two nonsampled residents (Residents 85 and 89) in Medication Cart C. This failure had the potential for the residents to be exposed to expired or deteriorated medications or biologicals. Findings: 1. Review of the facility's P&P titled Vials and Ampules of Injectable Medications dated ,d+[DATE] showed the date opened and initials of the first person to use the vials are recorded on multi-dose vials (on the vial label or an accessory label affixed for that purpose). On [DATE] at 1048 hours, an observation of Medication Room B and concurrent interview with LVN 8 was conducted. An uncapped one ml vial of testosterone cypionate (hormone) 200 mg/ml for Resident 39 was observed inside the medication refrigerator. An opened date and nurse initial were not observed on the vial or the box. The medication label on the vial of testosterone cypionate (hormone) 200 mg/ml showed to inject 0.5 ml (100 mg) intramuscularly one time a day every 14 days for low testosterone. LVN 8 verified the above findings and stated the multi-use vials should be labeled with the open date when first opened. On [DATE] at 1550 hours, an interview was conducted with the DON. The DON stated the multi-dose vials should be labeled when first opened with the date opened and nurse's initials. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled Medication Destruction dated ,d+[DATE] showed discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to pharmacy for credit, are destroyed. Medication is destroyed within 90 days from the date the medication was discontinued. Review of the facility P&P titled Storage of Medications dated ,d+[DATE] showed medications labeled for the individual residents are stored separately from floor stock medications when not in the medication cart. On [DATE] at 1115 hours, an inspection of Medication Room A was conducted with LVN 7. The following was observed inside Medication Room A: - two 1-liter bags of IVF containing 5% dextrose in water for Resident 115, - two 1-liter bags of IVF containing 10% dextrose in water for Resident 115, - two 1-liter bags of IVF containing 5% dextrose in ,d+[DATE] normal saline with 20 mEQ of potassium chloride for Resident 727, and - a 10-ounce bottle of magnesium citrate (saline laxative) with a medication label for Resident 726 was observed on the shelf with multiple bottles of magnesium citrate. On [DATE] at 1144 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 stated Resident 115 was discharged from the facility on [DATE], Resident 726 was discharged from the facility on [DATE], and Resident 727 was discharged on [DATE]. LVN 7 verified the above findings and stated the bottle of the magnesium citrate should not be placed in the stock supply and the bags of intravenous fluids should have been disposed of or placed in the designated location for the medication destruction. On [DATE] at 1540 hours, an interview was conducted with the DON. When asked what the process was for the medications of the discharged residents, the DON stated when the medications were discontinued, or the residents were discharged and not taking their medications, the medications would be placed in the designated area for medication destruction in the medication room. The DON further stated if the medications were resident specific (had a label on it), and if the resident was discharged or the medication was discontinued, the medication would not be put back in the stock supply and would be put in the designated location for the medication destruction. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Storage of Medications dated ,d+[DATE] showed orally administered medications are kept separate from the externally used medication, such as suppositories, liquids, and lotions. The medications requiring refrigeration or temperatures between 36 to 46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring. On [DATE] at 1153 hours, during an inspection of Medication Cart A with LVN 4, the following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an opened tube of topical hydrocortisone (corticosteroid) 2.5 % cream for Resident 45 was labeled with the date of [DATE]. The medication label showed for rectal use only, to apply to the rectum topically four times a day for hemorrhoids, for five days. The medication was observed stored in the same drawer with multiple bottles of OTC medications. - two opened 30 ml vials of Mucomyst (mucolytic, medicine that destroys or dissolves mucus) 20 % labeled with the dates of ,d+[DATE] and [DATE], for Resident 728 were observed inside a clear plastic bag. The label on the vial showed to discard opened containers after hours and to store in the refrigerator at , d+[DATE] degrees F after opening. LVN 4 verified the above findings and stated the hydrocortisone should have been removed and disposed after five days and should not be kept in the medication cart. LVN 4 also stated the two vials of Mucomyst should have been refrigerated and discarded after 96 hours of being opened. On [DATE] at 1540 hours, an interview was conducted with the DON. The DON stated when the medications were discontinued, or the residents were discharged and not taking their medications, the medications would not be in the medication carts, and would be placed in the designated area for the medication destruction in the medication room. The DON stated the external medications should be separated from the oral medications and should not be stored together in the medication cart. When asked about the policy for the medications that required refrigeration, the DON stated the medications should be refrigerated per the instructions. If the medications were not stored per the instructions, there may be a risk of decreased efficacy of the medication. The DON was informed and acknowledged the above findings. 4. On [DATE] at 1428 hours, an inspection of Medication Cart C was conducted with LVN 2. The following was observed: - an opened tube of triple antibiotic ointment, not labeled with the open date, and - two opened tubes of clobetasol propionate (corticosteroid) 0.05% cream for Residents 85 and 89, not labeled with the open date. LVN 2 acknowledged the above findings and stated the medication tubes should be labeled with an opened date when first opened. On [DATE] at 1540 hours, an interview was conducted with the DON. The DON stated all the medications should be labeled with the date and nurse's initials when opened. The DON was informed and acknowledged the above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49258 Based on observation, interview, facility P&P, and facility document review, the facility failed to ensure the nutritive content of the pureed food for the American menu was preserved and the food served was palatable as evidenced by: * The pureed vegetables were cooked and held in a hot oven more than one hour prior to the meal service. * The bread was hard and crusty in texture. These failures had the potential to not meet the nutritional needs for the residents consuming food prepared in the kitchen. Findings: 1. Review of the facility's Diet Type Report dated 7/18/24, showed 10 of 134 residents residing in the facility received pureed food prepared in the kitchen. Review of the reference titled How Cooking Affects the Nutrient Content of Foods dated 11/7/19, showed the following nutrients are often reduced during cooking: water-soluble vitamins: vitamin C and the B vitamins - thiamine (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxine (B6), folic acid (B9), and cobalamin (B12). https://www.healthline.com/nutrition/cooking-nutrient-content Review of the facility's P&P titled Puree Food Preparation revised 10/2023 showed each resident must receive and the facility must provide food that is prepared by methods that conserve nutritive value, flavor, and appearance. Review of the facility's document titled [NAME] Recipe, pureed vegetables, showed to remove the portions of the vegetables required from regular prepared recipe. Process until smooth, if necessary, add a small amount of reserved cooking liquid or hot water. If needed, gradually add thickener and process until smooth in consistency. All warm foods that were modified after preparation must be reheated to 165 degrees F or higher for 15 seconds. On 7/18/24 at 1004 hours, an observation of the puree preparation for the American menu and concurrent interview was conducted with the Main Cook. The Main [NAME] stated he cooked the green beans in hot water at 0950 hours. The Main [NAME] pureed the previously cooked green beans then placed the pureed green beans in a pan covered with a foil. At 1027 hours, the pureed green beans were placed in the oven at 350 degrees F until the lunch meal tray line began at 1148 hours, which was more than one hour. On 7/18/24 at 1604 hours, an interview was conducted with the RD Consultant. The RD Consultant stated the pureed foods should be cooked to preserve the nutritive value. The RD consultant was informed of the findings. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's Diet Type Report dated 7/18/24, showed 82 of 134 residents residing in the facility received diet with regular texture prepared in the kitchen. Review of the facility's menu spreadsheet for Summer Menu for Week 3 Wednesday dated 7/17/24, for lunch meal showed to serve vegetable lasagna, sauteed mixed squash, breadstick and butter, peach dump cake, and choice of beverage. On 7/17/24 at 1235 hours, a test tray inspection was conducted with the Kitchen Supervisor and RD Consultant. The breadstick was observed to be crusty and hard to chew in texture. The Kitchen Supervisor and RD Consultant verified the above findings.

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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. 49258 Based on observation, interview, and facility P&P review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure proper labeling and dating of the opened food in the freezer. * The facility failed to ensure the food preparation equipment were properly air dried prior to storage. * The facility failed to ensure the food preparation equipment were in good condition. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared from the kitchen. Findings: Review of the facility's Diet Type Report dated 7/18/24, showed 82 of 134 residents received diet with regular texture and 10 of 134 residents received pureed food prepared in the kitchen. 1. Review of the facility's P&P titled Food Safety and Food Storage revised 10/2023 under Refrigerated Storage, showed the following: - Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so its use-by date, or frozen (where applicable)/discarded; and - Keeping foods covered or in tight containers. On 7/16/24 at 0810 hours, during an initial tour of the kitchen, an observation of the freezer and concurrent interview was conducted with the Kitchen Supervisor. The following items were observed: - One opened plastic bag of frozen cookie dough was not labeled with an open date; - One opened plastic bag of potato hash brown was not labeled with an open date; and - One opened plastic bag of frozen waffles was not labeled with an open date. The cookie dough, potato hash brown, and waffles were observed with freezer burned (a condition caused by air reaching the surface of the food). The Kitchen Supervisor acknowledged the findings and stated these items were no longer good. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air- Drying Required showed the items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. Review of the facility's P&P titled Dry Storage-Dishes and Utensils revised 2/1/12, showed the dishes must be stored to promote air drying that is to use dish racks or trays with plastic mesh that allow air to circulate, and air dry the dishes. On 7/16/24 at 0825 hours, during the initial tour of the kitchen with the Kitchen Supervisor, five cutting boards were observed being stored in the cutting board rack wet. The Kitchen Supervisor verified the findings and stated the cutting boards were not air dried properly. 3. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 7/16/24 at 0825 hours, during the initial tour of the kitchen with the Kitchen Supervisor, one cutting board was observed heavily marred with knife marks. The Kitchen Supervisor acknowledged the finding and stated he would throw the food equipment.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and facility P&P review, the facility failed to implement their P&P on foods bought to the facility by the residents' family members or visitors to ensure the safe food handling practices were followed for one of 26 final sampled residents (Resident 95). * The facility failed to ensure opened food items at Resident 95's bedside were refrigerated when needed to be refrigerated. This failure had the potential for unsafe food handling which could lead to food borne illness. Findings: Review of the facility's P&P titled Use and Storage of Food Brought in by Family or Visitors revised 9/2023 showed the following: - It is the right of the residents of the facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident; and - All food items brought in that are manufactured and does not require refrigeration, may be kept in the resident room inside a lock tight container that is provided by the resident. According to the USDA's National Center for Home Food Preservation (NCHFP), it is recommended to store opened jars of jams and jellies in the refrigerator for up to one month. According to https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/shelf-stable-food, shelf-stable foods are foods that can be safely stored at room temperature, or on the shelf. These non-perishable products do not require refrigeration until According to https://contact.pepsico.com/faqs/product-information/how-long-can-i-drink-gatorade-after-the-bottle-has-been-opened, under normal conditions, Gatorade maintains fresh flavor approximately three to five days in a refrigerator if tightly capped and refrigerated within 24 hours of opening. Gatorade should be kept refrigerated or chilled (40 to 60 degrees F) after opening. According to https://www.sweetbabyrays.com /Sauces/Product-FAQs, for best quality, it is recommended using the BBQ sauce within four months of opening and to always refrigerate after opening. According to https://www.icantbelieveitsnotbutter.com/faq, it is recommended to refrigerate the product. On 7/16/24 at 0914, 0922 and 1022 hours; 7/17/24 at 0640 hours; and 7/18/24 at 0741 hours, the following was observed at Resident 95's bedside cabinet: - An opened bottle of strawberry jam; - An opened bottle of [NAME] pickles; (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An opened bottle of Gatorade; - An opened bottle of baby ribs sauce; and - An opened tub of I Can't Believe It's Not Butter butter (a blend of plant-based oils, water and other simple ingredients to deliver a buttery taste). On 7/16/22 at 1022 hours, an observation for Resident 95 and concurrent interview was conducted with CNA 3. CNA 3 verified the above findings. CNA 3 stated Resident 95 kept the food items at the resident's bedside. Resident 95 stated he kept the food items at the bedside and would ask the staff to refrigerate the food items that needed to be refrigerated. Medical record review for Resident 95 was initiated on 7/16/24. Resident 95 was readmitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 11/8/23, showed Resident 95 had the capacity to understand and make decisions. On 7/19/24 at 0948 hours, an observation for Resident 95 and concurrent interview was conducted with RN 2. An opened bottle of Gatorade, an opened bottle of baby ribs sauce; and an opened tub of I Can't Believe It's Not Butter butter were observed at Resident 95's bedside cabinet. RN 2 verified the above findings. RN 2 stated the residents could order food and or keep food at the bedside, but to refrigerate the food that needed to be refrigerated.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 49258 Based on observation and interview, the facility failed to store trash in a sanitary manner as evidenced by: * The facility failed to ensure three of fours dumpsters were properly covered. This failure had the potential to harbor pests. Findings: According to the US Food Code 2022, Section 5-501.113, Covering Receptacles, showed receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids. According to the USDA Food Code 2022- Annex 3, Public Health Reasons, outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 7/16/24 at 1620 hours, an observation of the trash disposal located outside the kitchen by the parking structure of the facility was conducted. The cover of three of four dumpsters were opened. The Administrator was informed of the findings. The Administrator was observed removing some of the boxes from the dumpsters and began to flatten those boxes.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 35346 Based on interview and facility documentation review, the facility failed to submit a complete and accurate direct care staffing information to CMS. This failure posed the risk of inaccurate auditable data reporting. Findings: Review of the CMS CASPER reports showed the facility triggered for extremely low staffing on weekends for the quarter from January 2024 to March 2024. On 7/19/24 at 1400 hours, a concurrent interview and facility document review was conducted with the Administrator. When asked about the data submitted to CMS related to the payroll and reports generated triggering extremely low staffing on weekends, the Administrator acknowledged he did not submit to CMS the complete hours staff worked.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on observation, interview, medical record review, facility P&P review, and facility document review, the facility failed to ensure the proper infection prevention practices for the facility's Water Management Program in the laundry room and for two of four residents reviewed for antibiotic use (Residents 116 and 120). * The facility did not have documentation to show they followed their Water Management Program. * The facility failed to maintain the clean enviroment in the clean linen area in the laundry room * The facility failed to ensure a physician's order was obtained for Resident 116 for contact isolation precaution related to ESBL in urine. In addition, the facility failed to ensure the CNA observed contact isolation precaution practices while providing care for Resident 116. * The facility failed to ensure the Enhanced Barrier Precaution was followed and practiced by providers, staff, and visitors for Resident 120. These failures had the potential for spread of infection in the facility. Findings: 1. Review of the facility's Water Management Program undated showed the following: * A waste Management Team binder containing all water management program documents. * Control Points-areas to be monitored and tested : -Check daily- all water fittings and medical devices using water. -Check monthly- HVAC vents to ensure no water is leaking, ice machines are checked for proper operation, for leaks and disinfected; eye wash stations sanitized and tested -Check quarterly-water heaters and HVAC to ensure there are no leaks, stagnant water, or biofilm. -Check annually-CDC elite Legionella testing, the results will be added to the water management binder. * Each time a control point is checked, the date and time should be entered on a log sheet. The Control Measure Documentation and Corrective Action Documentation logs were blank and did not show routine monitoring, and there were no prior Legionella test results located in the binder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 1106 hours, an interview and concurrent record review were conducted with the Maintenance Director. The Maintenance Director reviewed the Water Management Program's Control Points and stated they were doing all of the listed control points, except for the quarterly monitoring of water heaters and HVAC to ensure there are no leaks, stagnant water, or biofilm. The Maintenance Director stated they did not document the routine control point monitoring. On 7/12/24 at 1118 hours, an interview and concurrent record review were conducted with the Administrator. The Administrator verified the Water Management Program logs were incomplete and there was no documentation of the facility's last Legionella testing results, but stated the next test was scheduled for 7/30/24. 2. Review of the facility's P&P titled Infection Prevention and Control Program reviewed/revised 12/19/22, showed staff shall be handle, store and process linens to prevent the spread of infection. On 7/19/24 at 0814 hours, a tour of the laundry room was conducted with the Laundry Aide. During the tour, the following was observed in the clean linen area: - the mechanical lift slings hanging on a hook, with the bottom of the slings touching a trash bin; - a staff's sweater and purse on a hook next to a clean linen sorting/folding gown, with the sweater touching the gown; - a staff's purse sitting on a folding chair next to the clean linen table; and - a staff's food storage container sitting on a folded towel on the clean linen table shelf. On 7/19/24 at 0820 hours, the Maintenance Director entered the laundry room area, observed the above, and stated the mechanical lift slings should not be in contact with the trash bin and the staff should not have their personal belongings in the clean linen area. 48853 3. Review of facility's P&P titled Transmission-Based (Isolation) Precautions revised on April 2024 showed it is the facility's policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. The initiation of transmission-based precautions (Isolation Precaution) section showed, an order for transmission-based precaution/ isolation will be obtained for residents who are known or suspected to be infected or colonized with infection agents that require additional controls to prevent transmission effectively. The contact precautions section of the P&P showed: c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment; d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. VRE, C. difficile, noroviruses and other intestinal tract pathogens, RSV). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 0940 hours, during an initial tour, a contact precaution sign was observed by the Resident 116's door informing everyone must clean their hands, including before entering and when leaving the room. Providers and staff must put on gloves before room entry and discard gloves before room exit; and put on gown before room entry and discard gown before room exit. On 7/16/24 at 0945 hours, an interview with LVN 7 was conducted. LVN 7 verified Resident 116 was on contact isolation for ESBL in urine. Medical record review for Resident 116 was initiated on 7/16/24. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's Order Summary Report for July 2024 showed a physician's order dated 7/14/24, to administer Levaquin 500 mg one tablet by mouth one time a day for UTI for seven days. Review of Resident 116's urine culture laboratory results dated [DATE], showed urine culture, >100,000 CFU/ml Proteus mirabilis ESBL. * Further review of Resident 116's medical record failed to show a physician order for the contact isolation for ESBL in urine On 07/18/24 at 1411 hours, an interview and concurrent medical record review with LVN 7 was conducted. LVN 7 verified Resident 116 was taking Levaquin for UTI. LVN 7 verified the Resident 116's Order Summary Report for July 2024 failed to show a physician's order for contact isolation for ESBL of urine. On 7/18/24 at 1605 hours, CNA 12 was observed entering Resident 116's room, donned gloves without performing hand hygiene and touched the resident. CNA 12 did not wear a disposable gown. Resident 116 had a contact precaution sign posted on the wall prior entering the resident's room. On 7/18/24 at 1607 hours, an interview with CNA 12 was conducted. CNA 12 acknowledged Resident 116 was on contact precautions. CNA 12 confirmed she did not do hand hygiene and failed to wear gown prior entering the room. On 07/19/24 at 1157 hours, an interview and concurrent record review was conducted with the IP. The IP verified Resident 116 was on contact isolation precaution due to ESBL in urine. The IP verified there was no physician's order in place for contact isolation for Resident 116. The IP stated there should be a contact precaution order from the physician. The IP stated the CNAs were expected to wear at a least gown and gloves when entering the resident's room and should practice hand hygiene before and after wearing gloves. On 7/19/24 at 1520 hours, an interview with the DON was conducted. The DON was informed and acknowledged above findings. 4. Medical record review for Resident 120 was initiated on 7/16/24. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120's Order Summary Report for July 2024 showed a physician's order dated 7/4/24, for Enhanced Barrier Precautions related to PICC/Midline and chest tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/24 at 0908 hours, Resident 120 was in the room with no Enhanced Barrier Precaution observed posted outside of the room. On 7/19/24 at 1027 hours, an interview was conducted with RN 2. RN 2 verified the physician's order for Enhanced Barrier Precaution practices dated 7/4/24. RN 2 verified there were no sign posted outside of Resident 120's room to alert providers, staff, and visitors to follow enhanced barrier precaution practices. RN 2 stated Enhanced Barrier Precaution was not observed for the resident. On 7/19/24 at 1157 hours, an interview was conducted with the IP. The IP verified Resident 120 should had been placed on Enhanced Barrier Precaution as ordered by the physician. The IP stated she would put a sign and PPE set up by the resident's door.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48882 Based on observation, interview, facility document review, the facility failed to ensure the facility equipment were maintained in a safe operating condition when: * The facility failed to ensure corrective actions were taken when the quality control results for the glucometers (a device that measures the amount of sugar in the blood) were out of range for Medication Carts A and B. This failure had the potential risk of inaccuracy for the blood glucose test results. * The facility failed to ensure there was no ice buildup and brownish stain in the freezer of the medication refrigerator in Medication Room A. This failure had the potential for the equipment to not function in the way it was intended. Findings: 1. Review of the Assure Platinum (blood glucose monitoring system) Manual revised 06/22 showed to use Assure dose control solutions to check if the meter and test strips are working correctly as a system. Under the section Quality Checks, showed to compare the results (of the control solution) to the range printed on the test strip bottle. To make sure the result is within the acceptable range. If the results fall within this range, the meter and the test strip are working correctly. Do not use the system if the control solution result is out of range. Further review of the manual showed if (after troubleshooting) the control solution result still reads outside the range printed on the test strip bottle, the system may not be working correctly. Do not use the system to test blood glucose until the control system result is within range. a. Review of the facility's document titled Blood Glucose Monitoring System Daily Quality Control Record for July 2024 for Medication Cart A showed the following recorded control results: - dated 7/11/24, Level 1 control range was recorded as 84-105 mg/dL, Level 1 control result showed 81 mg/dL, and corrective action was recorded as 0; - dated 7/12/24, no entries for Level 1 and Level 2 control results; - dated 7/13/24, Level 1 control range was recorded as 84-105 mg/dL, Level 1 control result showed 83 mg/dL, and corrective action was recorded as 0; - dated 7/14/24, Level 1 control range was recorded as 84-105 mg/dL, Level 1 control result showed 83 mg/dL, and corrective action was recorded as 0; and - dated 7/17/24, Level 1 control range was recorded as 84-104 mg/dL, Level 1 control result showed 83 mg/dL, and corrective action was recorded as 0. b. Review of the facility document titled Blood Glucose Monitoring System Daily Quality Control Record for July 2024 for Medication Cart B showed the following recorded control results: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 7/3/24, Level 2 control range was recorded as 209-265 mg/dL, Level 2 control result showed 377 mg/dL, and corrective action was recorded as 0 and - dated 7/4/24, Level 2 control range was recorded as 209-265 mg/dL, Level 2 control result showed 386 mg/dL, and corrective action was recorded as 0. On 7/18/24 at 1430 hours, an inspection of Medication Cart B was conducted with LVN 5. LVN 5 stated the glucometer quality control test was done every day by the night shift licensed nurses. LVN 5 further stated if the control results were not within range, the nurse should do the quality control test again or change the glucometer. On 7/18/24 at 1540 hours, an interview and concurrent review of the Blood Glucose Monitoring System Daily Quality Control Record for July 2024 for Medication Carts A and B was conducted with the DON. The DON stated the glucometer quality control tests were done daily by the night shift nurses and recorded on the Blood Glucose Monitoring System Daily Quality Control Record. The DON further stated the licensed nurses were responsible for recording the test results and checking whether the control results were within range. When results were not within the range indicated on the test strip vials, the DON expected the licensed nurses to rerun the control test, check the batteries on the glucometer, and/or use another glucometer. The DON was asked about the potential risk if the glucometer was used when the control results were not within range, and stated there could be a potential for negative resident outcomes due to inaccurate blood glucose results. The DON verified and acknowledged the above findings. 2. On 7/17/24 at 1150 hours, an inspection of the medication refrigerator in Medication Room A was conducted with LVN 7. Ice buildup was observed in the inner top and outer bottom walls of the freezer compartment and a brownish stain was observed on the right inner wall of the freezer compartment of the refrigerator. LVN 7 verified the findings. On 7/17/24 at 1210 hours, an interview was conducted with RN 3. RN 3 stated every morning, the RN Supervisors were responsible for checking the temperature in the medication refrigerators and recording the temperatures in the log. RN 3 stated the maintenance was responsible for cleaning the medication refrigerators as needed. An interview and concurrent observation of the medication refrigerator inside of Medication Room A was conducted with RN 3. RN 3 verified the above findings. RN 3 stated she noticed the ice buildup when she was checking the temperature and did not inform the Maintenance Director. On 7/17/24 at 1238 hours, an interview and concurrent observation of the freezer compartment of the medication refrigerator in Medication Room A was conducted with the Maintenance Director. The Maintenance Director stated the cleaning of the medication refrigerators was not done on a routine schedule and medication refrigerators were cleaned as needed, when reported by the nurses. The Maintenance Director stated she had not been informed of recent ice buildup in the medication refrigerators. When asked about the brown discoloration on the freezer wall, the Maintenance Director stated she thought it was rust from the refrigerator screw. On 7/18/24 at 1540 hours, an interview was conducted with the DON. The DON stated the medication refrigerator should be kept clean and should not have ice buildup. The DON was informed and acknowledged the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, and facility P&P review, the facility failed to conduct the regular inspection of the residents' beds and assess for areas of risk for entrapment for four sampled residents (Residents 16, 32, 34, and 95) and four nonsampled (Residents 18, 49, 77, and 96) reviewed for the use of siderails. * The facility failed to conduct a routine bed inspection for all the facility beds. In Addition, the facility failed to ensure the entrapment assessments were properly conducted to identify areas of possible entrapment with the use of side rails and the facility failed to conduct the routine bed inspection for Residents 16, 18, 32, 34, 49, 77, 95, and 96. These failures had the potential for entrapments for these residents using the side rails. Findings: According to the FDA.gov there are seven zones that are tested on a bed system with bed rails to help reduce life-threatening entrapments associated with bed systems and bed rails. Review of the facility's P&P titled Bed Rails reviewed 11/23 showed the bed rails were to be assessed for risk of entrapment at least semi-annually. Review of the facility's halo rings (circular bed rails) warnings showed halos were to be tested at zone 4 for risk for entrapment. 1. On 7/17/24, at 0624 hours, Resident 16 was observed sleeping with her bilateral halos elevated. On 7/17/24, medical record review for Resident 16 was initiated. Resident 16 was admitted to the facility on [DATE]. Review the resident's medical record showed diagnoses included Alzheimer's dementia. Review of her quarterly MDS dated [DATE], showed Resident 16 had severe cognitive impairment. Review of Resident 16's Bed System Measurement Device Test Results Worksheet failed to show Zones 4, 6, or 7 were tested for entrapment risk. 2. On 7/16/24 at 0931 hours, Resident 32 was observed with her halo grab bars elevated. On 7/17/24 at 0623 hours, Resident 32 was observed lying to her left side with her upper bilateral halo grab bar elevated. On 07/18/24 at 0943 hours, Resident 32 was observed sleeping, lying on her left side, with her upper bilateral halos elevated. Medical record review for Resident 32 was initiated on 7/18/24. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's Bed System Measurement Device Test Results Worksheet failed to show Zones 4, 6, or 7 were tested for entrapment risk. 3. On 7/17/24, at 0621 hours, Resident 34 was observed in bed sleeping, with her bilateral 1/4 (quarter) upper bed rails elevated. Medical record review for Resident 34 was initiated on 7/17/24. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's H&P examination dated 4/8/24, showed Resident 34 was on hospice and diagnoses included asthma and anxiety. Review of Resident 34's Bed System Measurement Device Test Results Worksheet failed to show Zones 6 or 7 were tested for entrapment risk. On 07/18/24 at 1601 hours, concurrent interview and medical record review was conducted with the Maintenance Director. Review of the Bed System Measurement Device Test Results Worksheet (used to assess for risk for entrapment) for Residents 16, 32, and 34 showed Zones 4, 6 (headboard) and 7 (footboard) were not assessed. When asked about assessing for all zones of entrapment for the residents beds, the Maintenance Director stated she filled out the risk for entrapment form as per the training she received from a prior Maintenance Director. When asked about doing routine bed inspections, the Maintenance Director stated she did not conduct routine bed inspections. 49258 5. Review of Joerns Bed Frames EasyCare manufacturer's user-service manual dated 2023, under Maintenance/Inspection Information section, showed to visually inspect the bed and accessories for broken welds or cracks and check for loose hardware on a monthly basis. On 7/16/24 at 1000 hours, during the initial tour of the facility, Resident 18 was observed awake in bed with bilateral halo bed rails (a circular grab rail) elevated. Resident 18 stated she used the halo grab rails when turning in bed. On 7/18/24 at 0800 hours, Resident 18 was observed in bed with the bilateral halo bed rails elevated. Medical record review for Resident 18 was initiated on 7/18/24. Resident 18 was readmitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 4/19/24, showed Resident 18 had the capacity to understand and make decisions. Review of Resident 18's Order Summary Report showed a physician's order dated 4/18/23, for bilateral halos for ease of mobility in repositioning in bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 18's plan of care showed a care plan problem dated 4/18/23, addressing the use of the bilateral halos for bed mobility, transfers, turning and repositioning. The interventions/tasks included the facility to explain the risks for entrapment, and or muscular injury, including death and for the facility to monitor for any halo related injuries. Review of Resident 18's Bed rails - V2 dated 7/1/24, showed Resident 18 demonstrated difficulty with bed mobility or moving to a sitting position from bed and difficulty with standing/sitting balance. The box to show the facility visually checked the bed, mattress, and rail to ensure it was appropriate for the resident's dimension was not checked. On 7/18/24 at 1604 hours, an observation for Resident 18 and concurrent interview was conducted with CNA 9. Resident 18 was lying in bed with the bilateral halo bed rails elevated. CNA 9 verified the findings. CNA 9 stated Resident18 had been using the halo grab rails for a long time and used it to hold when turning side to side. On 07/18/24 at 1628 hours, an interview and concurrent facility document review for Resident 18 was conducted with LVN 11. LVN 11 verified Resident 18 used the bilateral halo. When asked about the entrapment assessment, LVN 11 stated the nurses did not do any entrapment assessment for Resident 18, but they called the maintenance department to install the bilateral halos for Resident 18. 6. On 7/16/24 at 1020 hours, during the initial tour of the facility, Resident 49 was observed awake in bed with bilateral halo bed rails elevated. Resident 49 stated she used the halo grab rails when turning in bed and when getting out from bed. On 7/18/24 at1400 hours, Resident 49 was observed in bed with the bilateral halo bed rails elevated. Medical record review for Resident 49 was initiated on 7/18/24. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 12/28/23, showed Resident 49 was alert to person, place, and time. Review of Resident 49's Order Summary Report showed a physician's order dated 2/23/21, for bilateral halos for assistance for turning and repositioning. Review of Resident 49's plan of care showed a care plan problem dated 3/25/21, to address the use of the bilateral halos for bed mobility, transfers, turning and repositioning. The interventions/tasks included the facility to explain the risks for entrapment, and or muscular injury, including death and for the facility to monitor for any halo related injuries. Review of Resident 49's Bed rails - V2 dated 5/17/24, showed the box to show the facility visually checked the bed, mattress, and rail to ensure it was appropriate for resident's dimension was not checked. On 7/18/24 at 1604 hours, an interview was conducted with CNA 9. CNA 9 verified Resident 49's used of bilateral halo grab rails. CNA 9 stated Resident 49 had been using the halo grab rails to grab when for repositioning. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/18/24 at 1628 hours, an interview and concurrent facility document review for Resident 49 was conducted with LVN 11. LVN 11 verified Resident 49 used the bilateral halos. When asked about the entrapment assessment, LVN 11 stated the nurses did not do any entrapment assessment for Resident 49, but they called the maintenance department to install the bilateral halos for Resident 49. 7. On 7/16/24 at 0941 hours, during the initial tour of the facility, Resident 77 was observed sleeping in bed with bilateral halo bed rails elevated. On 7/18/24 at 0830 hours, an observation and concurrent interview was conducted with Resident 77. Resident 77 was observed in bed with bilateral halo bed rails elevated. Resident 77 stated she held on the halos grab rails when changing position. Medical record review for Resident 77 was initiated on 7/18/24. Resident 77 was readmitted to the facility on [DATE]. Review of Resident 77's H&P examination dated 5/22/24, showed Resident 77 had the capacity to make medical decisions. Review of Resident 77's Order Summary Report showed a physician's order dated 7/1/24, for bilateral halos to aid turning and repositioning. Review of Resident 77's plan of care showed a care plan problem dated 3/25/21, addressing the use of the bilateral halos for bed mobility, turning and repositioning. The interventions/tasks included the facility to ensure halos for proper installations and to inspect halos for areas of entrapment. Review of Resident 77's Bed rails - V2 dated 7/1/24, showed Resident 77 was non-ambulatory, demonstrated difficulty with bed mobility or moving to a sitting position from bed, and difficulty with standing/sitting balance. The box to show the facility visually checked the bed, mattress, and rail to ensure it was appropriate for resident's dimension was not checked. On 7/18/24 at 1604 hours, an interview was conducted with CNA 9. CNA 9 verified Resident 77's used of the bilateral halo grab rails. CNA 9 stated Resident 77 had been using the halo grab rails to grab when for repositioning. On 07/18/24 at 1628 hours, an interview and concurrent facility document review for Resident 77 was conducted with LVN 11. LVN 11 verified Resident 77 used the bilateral halos. When asked about the entrapment assessment, LVN 11 stated the nurses did not do any entrapment assessment for Resident 77, but they called the maintenance department to install the bilateral halos for Resident 77. 8. On 7/16/24 at 0950 hours, during the initial tour of the facility, Resident 96 was observed sleeping in bed with bilateral one fourth side rails elevated. On 7/18/24 at 0900 hours, an observation and concurrent interview was conducted with Resident 96. Resident 96 was observed in bed with bilateral one fourth side rails elevated. Resident 96 did not answer any questions and just stared when being asked. Medical record review for Resident 96 was initiated on 7/18/24. Resident 96 was admitted to the facility on [DATE]. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 96's H&P examination dated 6/28/23, showed Resident 96 was oriented to person, place, and time. Review of Resident 96's Order Summary Report showed a physician's order dated 7/13/24, for bilateral one fourth side rails for aid turning and repositioning. Review of Resident 96's plan of care showed a care plan problem dated 3/2/24, addressing the use of bilateral one fourth side rails for bed mobility, turning and repositioning. The interventions/tasks included the facility to inspect one fourth side rails for sharp edges, areas of entrapment. Review of Resident 96's Bed rails - V2 dated 3/2/24, showed the rehabilitation recommended bilateral side rails as enabler for turning and repositioning. The box to show the facility visually checked the bed, mattress, and rail to ensure it was appropriate for resident's dimension was checked. On 7/18/24 at 1155 hours, an interview was conducted with CNA 10. CNA 10 verified Resident 96's used of the bilateral one fourth side rails. CNA 10 stated Resident 96 had been using the side rails for a long time and Resident 96 could hold to the side rails when being turned. On 07/18/24 at 1640 hours, an interview and concurrent facility document review for Resident 96 was conducted with LVN 6. LVN 6 verified Resident 96 used the bilateral one fourth side rails. When asked about the entrapment assessment, LVN 6 stated the nurses did not do any entrapment assessment for the side rails, but they would call the maintenance department to install the side rails. On 7/19/24 at 1041 hours, an interview and concurrent facility document review for Residents 18, 49, 77, and 96 was conducted with the Maintenance Director. When asked about bed inspection, the Maintenance Director stated there was no routine bed inspection conducted in the facility but would only check the resident beds when called by the facility staff to check or repair the facility bed. The Maintenance Director stated when a bed repair was conducted, she would then check the motors, pins, and the bed remote control. The Maintenance Director stated she did not check the brakes for the resident beds because most of the beds in the facility did not have any break controls. When asked for the documentation of the bed inspection conducted during bed repairs, the Maintenance Director was not able to show documentation. When asked for the entrapment assessment, the Maintenance Director she was responsible for the installation of the halos and side rails, and for the entrapment assessment of all the beds in the facility. The Maintenance Director stated she did not used a safety measuring device to measure the entrapment zones on each of the bed, but only installed the halos and side rails. The Maintenance Director stated she documented the results in the worksheet form, to which she showed the Bed System Measurement Device Test Results Worksheet for each of the resident's bed with halos or side rails in the facility. Review of Resident 18's Bed System Measurement Device Test Results Worksheet dated 7/9/24, showed the bed assessment passed, and P was circled for Zones 1, 2, and 3. The worksheet failed to show an entrapment assessment for Zones 4, 6, and 7 was conducted. Review of Resident 49's Bed System Measurement Device Test Results Worksheet dated 7/9/24, showed the bed assessment passed, and P was circled for Zones 1, 2, and 3. The worksheet failed to show an entrapment assessment for Zones 4, 6, and 7 was conducted. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 77's Bed System Measurement Device Test Results Worksheet dated 7/9/24, did not show if the bed assessment was passed, and P was circled for Zones 1, 2, and 3. The worksheet failed to show an entrapment assessment for Zones 4, 6, and 7 was conducted. Review of Resident 96's Bed System Measurement Device Test Results Worksheet dated 7/9/24, showed the bed assessment passed, and P was circled for Zones 1, 2, and 3. The worksheet failed to show an entrapment assessment for Zones 4, 6, and 7 was conducted. When asked about the P and F indicated on the different zones in the worksheet form, the Maintenance Director stated P meant passed, which meant the halo grab rails were installed on those zones, and F meant failed, or the halos were not installed on those zones. The Maintenance Director indicated P on Zones 1, 2, and 3 on the worksheet form for Residents 18, 49, 77, and 96's bed because the halos or side rails were installed on Zones 1, 2, and 3. The Maintenance Director verified the Zone 4, 6, and 7 were not assessed for entrapment. When asked if she was familiar and had received training with the zones of entrapment, the Maintenance Director stated she was not familiar with the different zones of entrapment. 39453 9. Review of Joerns Bed Frames EasyCare manufacturer's user-service manual dated 2023, under Maintenance/ Inspection Information section, showed to visually inspect the bed and accessories for broken welds or cracks and check for loose hardware on a monthly basis. On 7/16/24 at 0914 hours, during the initial tour of the facility, Resident 95 was observed in bed with the bilateral halo bed rails (a circular grab rail) elevated. Resident 95 stated he used the halo grab rails to reposition himself. On 7/16/24 at 0922 and on 1022 hours, on 7/17/24 at 0640 hours, and on 7/18/24 at 0741 hours, Resident 95 was observed in bed with the bilateral halo bed rails elevated. Medical record review for Resident 95 was initiated on 7/16/24. Resident 95 was readmitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 11/8/23, showed Resident 95 had the capacity to understand and make decisions. Review of Resident 95's Order Summary Report showed a physician's order dated 2/14/24, for bilateral halos for bed mobility, turning and repositioning. Review of Resident 95's plan of care showed a care plan problem dated 2/14/24, addressing the use of bilateral halos for bed mobility, transfers, turning and repositioning. The interventions/tasks included the facility to inspect bilateral halos for sharp edges, areas of entrapment, and for proper installation. Review of Resident 95's Bed rails - V2 dated 2/14/24, showed Resident 95 was non-ambulatory, and demonstrated difficulty with bed mobility or moving to a sitting position from bed. The box to show the facility visually checked the bed, mattress, and rail to ensure it was appropriate for resident's dimension was not checked. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24 at 0805 hours, an observation for Resident 95 and concurrent interview was conducted with CNA 4. Resident 95 was lying in bed, with bilateral halo bed rails elevated. CNA 4 verified the findings. CNA 4 stated Resident 95 used the halo grab bars when turning side to side. On 07/19/24 at 0933 hours, an interview and concurrent facility document review for Resident 95 was conducted with RN 2. RN 2 verified Resident 95 used the bilateral halos. When asked about the entrapment assessment, RN 2 stated the nurses did not do any entrapment assessment for Resident 95, but only called the maintenance department to install the bilateral halos for Resident 95. On 7/19/24 at 1041 hours, an interview and concurrent facility document review for Resident 95 was conducted with the Maintenance Director. When asked about bed inspection, the Maintenance Director stated there was no routine bed inspection conducted in the facility, but would only check the resident beds when called by the facility staff to check or repair the facility bed. The Maintenance Director stated when a bed repair was conducted, she would then check the motors, pins, and the bed remote control. The Maintenance Director stated she did not check the brakes for the resident beds because most of the beds in the facility did not have any break controls. When asked for the documentation of the bed inspection conducted during bed repairs, the Maintenance Director was not able to show documentation. When asked for the entrapment assessment, the Maintenance Director she was responsible for the installation of the halos and side rails, and for the entrapment assessment of all the beds in the facility. The Maintenance Director stated she did not used a safety measuring device to measure the entrapment zones on each of the bed, but only installed the halos and side rails. The Maintenance Director she documented the results in the worksheet form, to which she showed the Bed System Measurement Device Test Results Worksheet for each of the resident's bed with halos or side rails in the facility. Review of Resident 95's Bed System Measurement Device Test Results Worksheet dated 4/30/24, showed the bed assessment passed, and P was circled for Zones 1, 2, and 3. The worksheet failed to show an entrapment assessment for Zone 7 was conducted. Review of Resident 95's Bed System Measurement Device Test Results Worksheet dated 4/30/24, showed the bed make was Joerns and the bed assessment passed. The worksheet showed the letter P was circled for Zones 1, 2, and 3. However, the worksheet failed to show an entrapment assessment for Zone 7 was conducted. Review of Resident 95's Bed System Measurement Device Test Results Worksheet dated 7/9/24, did not show the bed make, but showed the bed assessment passed. The worksheet showed the letter P was circled for Zones 1, 2, and 3. However, the worksheet showed N/A for Zone 7. When asked about the P and F indicated on the different zones in the worksheet form, the Maintenance Director stated P meant passed, which meant the halo grab rails was installed on those zones, and F meant failed, or the halo was not installed on those zones. The Maintenance Director she indicated P on Zones 1, 2, and 3 on the worksheet form for Resident 95's bed because the halos were installed on Zones 1, 2, and 3. The Maintenance Director verified the Zone 7 was not assessed for entrapment. When asked if she was familiar and had received training with the zones of entrapment, the Maintenance Director she was not familiar with the different zones of entrapment.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49258 Based on observation, interview, and facility P&P review, the facility failed to ensure the audible sound and visual light could be heard and seen from the call light panel at the nurse's stations for 16 of 63 rooms. * Room N's restroom call light did not light at the door and did not sound at the Nursing Station B's call panel. * Room O's restroom call light did not light at the door and did not light and sound at the Nursing Station B's call panel. * Resident 16's call light had a dim light above the door and was not audible. * The facility failed to ensure the call light system for Rooms A to M had an audible sound in the call light panel at the Nursing Station A. These failures had the potential for the staff not to hear and see the call light resulting in delayed provision of assistance to the residents. Findings: Review of the facility's P&P titled Call Light, Use Of revised 11/2021 showed: - Promptly report any defective light to the Maintenance/Engineering Department and/or charge nurse; - Document location of any defective call lights in the Maintenance log; - If a call light is not working, provide the resident with an alternative way to contact staff for assistance until call light is repaired. In lieu of another device, may implement resident checks every 15 minutes; and - When the call light system has malfunctioned or is not available, the facility shall assign a staff member in the regular staffing assignment to round every 15 minutes and document those rounds according to established protocol. The staff member shall have no additional duties during the 15 minute checks until such time as the system is repaired and the 15 minute checks are no longer necessary. 1. On 7/17/24 at 0802 hours, an observation of call light in Room N and concurrent interview with the ADON and CNA 8 was conducted. Residents 8, 43, and 54 were observed lying in their bed asleep. The ADON tested Room N's restroom call light. The call light did not light at the door and did not sound at the Nursing Station B's call panel as observed by another surveyor. CNA 8 verified there was no light at the door of Room N when the ADON turned on the restroom's call light. CNA 8 stated it was important for the call light to work not only for the residents but for the staff also if they needed assistance from the other staff. The ADON and CNA 8 stated the light above the room's door should light when the restroom's call light was turned on. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 0806 hours, an observation of the call light panel in Nursing Station B and concurrent interview with RN 1 was conducted by another surveyor. RN 1 verified there was no sound from Room N at the call panel when the restroom's call light was turned on. RN 1 stated when the room's restroom call light was pushed, it would make a louder and longer beep to differentiate from the bed call lights. a. Medical record review for Resident 8 was initiated on 7/17/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 4/19/24, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 8's MDS under Section G- Functional Abilities and Goals dated 7/12/24, showed Resident 8 needed substantial to maximal assistance for toilet transfer and dependent for tub/shower transfer. b. Medical record review for Resident 43 was initiated on 7/17/24. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 6/10/24, showed Resident 43 had the capacity to understand and make medical decisions. Review of Resident 43's MDS under Section G- Functional Abilities and Goals dated 6/10/24, showed Resident 43 was dependent with toileting and hygiene. c. Medical record review for Resident 54 was initiated on 7/17/24. Resident 54 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 54's H&P examination dated 7/1/24, showed Resident 54 could make her needs known. Review of Resident 54's MDS under Section G- Functional Abilities and Goals dated 6/10/24, showed Resident 54 was dependent with toileting, hygiene, and shower. On 7/17/24 at 1011 hours, the survey team had a meeting with the Administrator, DON, Regional Director, and VP of Clinical Operations. They were informed of the call light system concerns. The Administrator stated there was an issue with the wiring on the call light panel. The Administrator stated the facility's call light system had an audible and visual function, and it was required that there should be an audible sound and visual or light from the call light panel. 2. On 7/17/24 at 0828 hours, an observation of the call light in Room O and concurrent interview with the ADON and Maintenance Assistant was conducted. The ADON tested Room O's restroom call light. The call light did not light at the door and there were no light and sound at the Nursing Station B's call panel as observed by another surveyor. The Maintenance Director verified there was no light by the door when the ADON pressed the call light in Room O's restroom. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 0830 hours, an observation of the call light panel in Nursing Station B and concurrent interview with the Maintenance Assistant was conducted by another SA. The Maintenance Assistant verified there was no light and sound from Room O in the call panel when the restroom's call light was turned on. On 7/17/24 at 0835 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director changed the light bulb above Room O's door, but it did not work. The Maintenance Director stated the call light needed to be fixed immediately. On 7/17/24 at 0927 hours, an observation and concurrent interview was conducted with Resident 71. Resident 71 stated she used the restroom. Resident 71 further stated she walked with a walker and at times would lose her balance. Medical record review for Resident 71 was initiated on 7/17/24. Resident 71 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 71's H&P examination dated 6/26/24, showed Resident 71 had the capacity to make decisions. Review of Resident 71's MDS under Section G- Functional Abilities and Goals dated 6/28/24, showed Resident 71 needed partial to moderate assistance with toileting and shower. On 7/17/24 at 1011 hours, the survey team had a meeting with the Administrator, DON, Regional Director, and VP of Clinical Operations. They were informed of the call light system concerns. The Administrator stated there was an issue with the wiring on the call light panel. The Administrator stated the facility's call light system had an audible and visual function, and it was required that there should be an audible sound and visual or light from the call light panel. 35346 3. On 07/16/24 at 1257 hours, Resident 16 verbalized wanting something else to eat and pressed on the call light. The call light was observed not audible and the call light bulb outside Resident 16's room was observed to be dim. On 07/16/24 at 1301 hours, Resident 16's call light was observed dim and not audible outside the resident room nor at the nurse station. Female staff were observed walking by Resident 16's room without attending to Resident 16's call light. On 07/16/24 at 1311 hours, a female CNA staff walk by Resident 16's room. Resident 16's call light was observed dim and not audible. On 7/16/24, medical record review for Resident 16 was initiated. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's quarterly MDS showed Resident 16 was cognitively impaired. This MDS showed Resident 16 needed help with most of her ADLs. On 07/17/24 at 0714 hours, CNA 11 verified the call lights for Resident 16 and her room mate (Resident 83) were not audible and did not light up at the nurse station. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	39453 4. On 7/17/24 at 0635 hours, the call light for Room F was observed lit up on the call light panel at Nursing Station A; however, there was no audible sound heard from the call light panel. CNA 5 was observed in Nursing Station A. When asked about the call light for Room F, CNA 5 verified the call light was on but there was no audible sound from the call light panel. On 7/17/24 at 0640 hours, an observation for the call lights for Rooms A to M and concurrent interview was conducted with CNAs 5 and 6. CNAs 5 and 6 were asked to test the bed call lights from Rooms A to M. When CNAs 5 and 6 pressed the bed call lights, the light above from Rooms A to M lit up and the lights on the call light panel were on, but there were no audible sound coming from the call light panel in Nursing Station A. CNAs 5 and 6 verified the above findings. CNAs 5 and 6 stated the staff were always at the station so they were able to see the call light on the call light panel. When asked how many residents were assigned to each CNA, CNAs 5 and 6 stated they both have 15 residents each. The following residents were observed in each room in Nursing Station A: a. Room A was observed with the following residents: * Medical record review for Resident 42 was initiated on 7/16/24. Resident 42 was readmitted to the facility on [DATE]. Review of Resident 42's H&P examination dated 5/28/24, showed Resident 42 had no capacity to understand and make decision. Review of Resident 42's MDS dated [DATE], showed Resident 42 had severe cognitive impairment, with no impairment to upper and lower extremities, and needed supervision with mobility. * Medical record review for Resident 29 was initiated on 7/16/24. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's H&P Examination dated 7/16/24, showed Resident 29 had the capacity to understand and make decisions. Review of Resident 29's MDS dated [DATE], showed Resident 29 was cognitively intact, with impairment to one side of upper extremities, and needed supervision with mobility. b. Room B was observed with the following residents: * Medical record review for Resident 60 was initiated on 7/16/24. Resident 60 was admitted to the facility on [DATE]. Review of Resident 60's H&P-SNF Readmission form dated 5/8/24, showed Resident 60 was able to make medical decisions. Review of Resident 60's MDS dated [DATE], showed Resident 60 had no impairment to upper and lower extremities, and dependent with mobility. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Medical record review for Resident 105 was initiated on 7/16/24. Resident 105 was admitted to the facility on [DATE]. Review of Resident 105's MDS dated [DATE], showed Resident 105 had moderate cognitive impairment, with no impairment to upper and lower extremities, and needed partial/ moderate assistance with mobility. c. Room C was observed with the following residents: * Medical record review for Resident 127 was initiated on 7/16/24. Resident 127 was admitted to the facility on [DATE]. Review of Resident 127's Internal Medicine H&P/ Progress Note dated 7/12/24, showed Resident 127 had no capacity to understand and make decision. * Medical record review for Resident 128 was initiated on 7/16/24. Resident 128 was admitted to the facility on [DATE]. Review of Resident 128's H&P examination dated 7/5/24, showed Resident 128 had the capacity to understand and make decision. Review of Resident 128's MDS dated [DATE], showed Resident 128 had moderate cognitive impairment, with impairment to one side of upper extremities, and needed partial/ moderate assistance with mobility. * Medical record review for Resident 70 was initiated on 7/16/24. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70's H&P examination dated 7/1/24, showed Resident 70 was oriented times three (to person, place, and time). Review of Resident 70's MDS dated [DATE], showed Resident 70 had moderate cognitive impairment, with no impairment to upper and lower extremities, and dependent with mobility. d. Room D was observed with the following residents: * Medical record review for Resident 28 was initiated on 7/16/24. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P Examination dated 6/2/24, showed Resident 28 had the capacity to understand and make decision. Review of Resident 28's MDS dated [DATE], showed Resident 28 had moderate cognitive impairment, with no impairment to upper and lower extremities, and needed partial/ moderate assistance with mobility. * Medical record review for Resident 19 was initiated on 7/16/24. Resident 19 was readmitted to the facility on [DATE]. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 19's H&P examination dated 5/9/24, showed Resident 19 had the capacity to understand and make decision. Review of Resident 19's MDS dated [DATE], showed Resident 19 had moderate cognitive impairment, with impairment to one side of upper and lower extremities, and needed partial/ moderate assistance with mobility. e. Room E was observed with the following residents: * Medical record review for Resident 824 was initiated on 7/16/24. Resident 824 was admitted to the facility on [DATE]. Review of Resident 824's H&P examination dated 7/3/24, showed Resident 824 had the capacity to understand and make decision. Review of Resident 824's MDS dated [DATE], showed Resident 824 had moderate cognitive impairment, with no impairment to upper and lower extremities, and needed supervision with mobility. * Medical record review for Resident 129 was initiated on 7/16/24. Resident 129 was admitted to the facility on [DATE]. f. Room F was observed with the following residents: * Medical record review for Resident 2 was initiated on 7/16/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 6/17/24, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's MDS dated [DATE], showed Resident 2 had moderate cognitive impairment, with impairment to one side of upper extremities, and needed substantial/ maximal assistance with mobility. * Medical record review for Resident 130 was initiated on 7/16/24. Resident 130 was admitted to the facility on [DATE]. Review of Resident 130's Internal Medicine H&P/ Progress Note dated 7/17/24, showed Resident 130 had the capacity to understand and make decision. g. Room G was observed with the following residents: * Medical record review for Resident 21 was initiated on 7/16/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Internal Medicine H&P/ Progress Note dated 4/19/24, showed Resident 21 had the capacity to understand and make decision. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 21's MDS dated [DATE], showed Resident 21 had moderate cognitive impairment, with no impairment to upper extremities, and needed substantial/ maximal assistance with mobility. * Medical record review for Resident 5 was initiated on 7/16/24. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's H&P examination note dated 5/28/24, showed Resident 5 had a normal cognition. Review of Resident 5's MDS dated [DATE], showed Resident 70 had moderate cognitive impairment, with no impairment to upper extremities, and needed partial/ moderate assistance with mobility. * Medical record review for Resident 51 was initiated on 7/16/24. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's Progress Note H&P dated 6/15/24, showed Resident 51 was oriented times three (to person, place, and time). Review of Resident 51's MDS dated [DATE], showed Resident 51 had moderate cognitive impairment, with no impairment to upper extremities, and needed partial/ moderate assistance with mobility. h. Room H was observed with the following residents: * Medical record review for Resident 131 was initiated on 7/16/24. Resident 131 was admitted to the facility on [DATE]. Review of Resident 131's H&P examination dated 7/8/24, showed Resident 131 had the capacity to understand and make decisions. Review of Resident 131's MDS dated [DATE], showed Resident 131 was cognitively intact, with no impairment to upper and lower extremities, and needed partial/ moderate to substantial/ maximal assistance with mobility. * Medical record review for Resident 14 was initiated on 7/16/24. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination note dated 6/27/24, showed Resident 14 was confused. Review of Resident 14's MDS dated [DATE], showed Resident 14 had severe cognitive impairment, with no impairment to upper extremities, and dependent with mobility. i. Room I was observed with the following resident: * Medical record review for Resident 728 was initiated on 7/16/24. Resident 728 was admitted to the facility on [DATE]. Review of Resident 728's H&P examination dated 7/12/24, showed Resident 728 had the capacity to understand and make decisions. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 728's MDS dated [DATE], showed Resident 728 had moderate cognitive impairment, with no impairment to upper and lower extremities, and needed partial/ moderate assistance with mobility. j. Room J was observed with the following residents: * Medical record review for Resident 111 was initiated on 7/16/24. Resident 111 was admitted to the facility on [DATE]. Review of Resident 111's Skilled Nursing H&P examination note dated 6/27/24, showed Resident 111 was partially able to make medical decisions. Review of Resident 111's MDS dated [DATE], showed Resident 70 had severe cognitive impairment, with no impairment to upper and lower extremities, and dependent with mobility. * Medical record review for Resident 825 was initiated on 7/16/24. Resident 825 was admitted to the facility on [DATE]. Review of Resident 825'S Skilled Nursing H&P examination note dated 6/27/24, showed Resident 825 was able to make medical decisions. Review of Resident 825's MDS dated [DATE], showed Resident 70 had moderate cognitive impairment, with no impairment to upper extremities, and needed partial/ moderate assistance with mobility. * Medical record review for Resident 45 was initiated on 7/16/24. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's H&P examination dated 6/2/24, showed Resident 45 had the capacity to understand and make decisions. Review of Resident 45's MDS dated [DATE], showed Resident 45 had moderate cognitive impairment, with no impairment to upper and lower extremities, and needed partial/ moderate assistance with mobility. k. Room K was observed with the following residents: * Medical record review for Resident 133 was initiated on 7/16/24. Resident 131 was readmitted to the facility on [DATE]. Review of Resident 133's Internal Medicine H&P/ Progress Note dated 7/8/24, showed Resident 133 had no capacity to understand and make decisions. Review of Resident 133's MDS dated [DATE], showed Resident 133 had moderate cognitive impairment, with impairment to one side of upper and lower extremities, and dependent with mobility. * Medical record review for Resident 104 was initiated on 7/16/24. Resident 104 was admitted to the facility on [DATE]. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 104's H&P examination note dated 5/14/24, showed Resident 104 had a normal cognition and oriented x 3. Review of Resident 104's MDS dated [DATE], showed Resident 104 had moderate cognitive impairment, with no impairment to upper extremities, and needed substantial/ maximal assistance with mobility. l. Room I was observed with the following residents: * Medical record review for Resident 46 was initiated on 7/16/24. Resident 104 was admitted to the facility on [DATE]. Review of Resident 46's Internal Medicine H&P/ Progress Note dated 6/28/24, showed Resident 46 had the capacity to understand and make decisions. Review of Resident 46's MDS dated [DATE], showed Resident 46 had moderate cognitive impairment, with no impairment to upper and lower extremities, and needed partial/ moderate assistance with mobility. * Medical record review for Resident 826 was initiated on 7/16/24. Resident 826 was admitted to the facility on [DATE]. Review of Resident 826's MDS dated ,d+[DATE], showed Resident 826 was cognitively intact, with no impairment to upper and lower extremities, and needed substantial/ maximal assistance with mobility. * Medical record review for Resident 63 was initiated on 7/16/24. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Internal Medicine H&P/ Progress Note dated 7/5/24, showed Resident 63 had capacity to understand and make decisions. Review of Resident 63's MDS dated [DATE], showed Resident 63 had was cognitively intact, with impairment to one side of upper extremities, and needed partial/ moderate to substantial/ maximal assistance with mobility. m. Room M was observed with the following resident: * Medical record review for Resident 20 was initiated on 7/16/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P Examination dated 5/14/24, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's MDS dated [DATE], showed Resident 20 had was cognitively intact, with no impairment to upper extremities, and needed partial/ moderate assistance with mobility. On 7/17/24 at 0657 hours, there were no staff observed at Nursing Station A. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/24 at 0700 hours, an observation for the call light panel at Nursing Station A and concurrent interview was conducted with LVN 10. LVN 10 stated she was the charge nurse at Nursing Station A, with 14 rooms from Rooms A to M. LVN 10 verified the call lights at Nursing Station A, when pressed, would light up above the rooms, and on the call light panel; but there was no audible sound from the call light panel. When asked if this had been an ongoing call light panel issue, LVN 10 stated it had been three days when she noticed the call light panel had no audible sound. When asked if a report had been made regarding the call light panel, LVN 10 stated she did not report but should have reported to the maintenance department. On 7/17/24 at 0714 hours, an observation for the call light panel at Nursing Station A and concurrent interview was conducted with LVNs 4 and 9. LVNs 4 and 9 verified the call lights in the call light panel were working, but there was no audible sound from the call light panel. When asked if this had been an ongoing call light panel issue, LVN 9 stated he could not remember if the call light panel had an audible sound when he worked. LVN 4 stated he worked yesterday but not sure if the call light panel had an audible sound. On 7/17/24 at 0820 hours, an observation for the call light panel at Nursing Station A and concurrent interview was conducted with CNA 7. CNA 7 verified the call lights in the call light panel were working, but there was no audible sound from the call light panel. When asked if this had been an ongoing call light panel issue, CNA 7 stated she knew there was no noise from the call light panel at Nursing Station A, but she had no idea how long it has been like that, maybe a week. When asked if a report had been made regarding the call light panel, CNA 7 stated she did not report but should have reported to the maintenance department. On 7/17/24 at 1011 hours, the survey team had a meeting with the Administrator, DON, Regional Director, and VP of Clinical Operations. They were informed of the call light system concerns. The Administrator stated there was an issue with the wiring on the call light panel. The Administrator stated the facility's call light system had an audible and visual function, and it was required that there should be an audible sound and visual or light from the call light panel.