STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50147 Based on observation, interview, and record review, the facility failed to ensure controlled medications (medications that can be easily abused and are under strict government control) were fully accounted for when they were signed out of the Controlled Drug Record (CDR, an inventory or count sheet) but not documented on the medication administration record (MAR) for three out of five residents (Residents 12, 19, and 202); and a controlled medication for a resident (Resident 204) was destroyed without a witness' signature as per facility policy and procedure. The failures had the potential for medication errors and controlled drug abuse or diversion (when healthcare providers obtain or use prescription medicines illegally). Findings: 1. During an interview on 10/29/24 at 2:27 p.m., with the ADON (Assistant Director of Nursing) about as needed medications, she explained that when the resident requested a medication, the nurse assesses the resident, reviews the physician's order, obtains the medication from the med cart, administers it to the resident, documents it on the MAR & the narcotic record, and then reassesses the resident for effectiveness within one hour. A review of Resident 12's clinical record indicated a physician's order, dated 2/2/24, for Norco (a potent narcotic for pain) 5-325 milligrams (mg, unit of measurement), give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. During a concurrent interview and record review on 10/29/24 at 2:34 p.m., with both the Director of Nursing (DON) and ADON in their office, a review of Resident 12's for Norco 5-325mg and the August, September, and October 2024 MARs indicated the nursing staff signed out of the CDR, but did not document on the MAR to show the medication was administered to the Resident on 6 occasions: 8/21/24 at 0017, 9/5 at 2145, 9/18 at 0210, 9/24 at 2232, 10/14 at 2108, 10/22 at 0231 for a total of 6 tablets. They confirmed there is no documentation in the MAR for the above dates to show they were administered to the resident. 2. A review of Resident 19's clinical record indicated a physician's order, date 6/8/24, for tramadol (a controlled medication for pain) 50 mg, give 1 tablet by mouth every 6 hours as needed for moderate to severe pain. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/29/24 at 2:44 p.m., with both the DON and the ADON, a review of Resident 19's CDR for tramadol 50 mg, and the August, September, and October 2024 MARs indicated the staff signed out of the CDR but no documentation on the MAR: on 8/17/24 at 2315, 8/24/24 at 1119, 9/15/24 at 1600, and 10/6/24 at 1100 for a total of 4 tabs. They stated their investigation confirmed no documentation of these medications. 3. A review of Resident 202's clinical record indicated a physician's order, dated 10/9/24, for oxycodone 5 mg, give 1 tablet by mouth every 6 hours as needed for moderate pain AND give 2 tablets by mouth every 6 hours as needed for severe pain. During a concurrent interview and record review on 10/29/24 at 2:48 p.m., with the DON and the ADON, a review of Resident 202's CDR for oxycodone and the October 2024 MAR indicated the nursing staff signed out of the CDR 2 tablets on 10/17/24 at 2013 but did not document the administration on the MAR. They confirmed this finding and acknowledged 2 oxycodone tablets were unaccounted for. On 10/29/24 at 2:59 p.m., the DON and ADON reviewed Resident 12's , Resident 202's, and Resident 19's progress notes confirmed there was no supporting documentation to indicate these medications were given to these residents. The DON acknowledged that without documentation, the computer system would not trigger the re-assessment and prevent the nursing staff from giving it again too soon, posing the potential for medication errors. The DON stated, I'm pretty sure they are lazy to document it. During a concurrent interview and record review on 10/29/24 at 3:12 p.m., with RN1 in the presence of the DON and ADON, RN1 was informed he did not document medication administration on the MAR for Residents 12 and 19. When asked what happened, he replied, The system didn't save when I changed computers. When noted why it happened multiple times, he replied, Maybe I forgot to document it. During a concurrent interview and record review on 10/29/24- at 3:12 p.m., with LVN1 who did not document on MAR on 10/14/24 at 9:08 p.m., for Resident 12, she stated Resident 12 always asks for her pain meds . I forgot to document. Both RN1 and LVN1 acknowledged these are controlled meds and need to be fully accounted for. The facility's undated policy and procedure (P&P) titled, Controlled Substances Policy Statement . Policy Interpretation and Implementation, under the section titled Dispensing and Reconciling Controlled Substances, indicated . #2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: . b. Medication administration records . #5.c. The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met (example: a resident receiving a pain medication complains of unrelieved pain) . 4. During a concurrent interview and record review on 10/29/24 at 9:40 a.m., with the DON in her office, the storing and wasting of controlled substances was reviewed. A review of the CDR for Resident 204 indicated, on 10/12/24 at 5:08p.m., an oxycodone 5 mg was wasted but there was only one set of initials on the form. The DON then signed the document in the surveyor's presence and stated she clearly remembered witnessing the waste with the nurse. She repeatedly acknowledged it should have been double signed at the time of waste, and stated wasting requires two sets of initials. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's undated (P&P) titled, Controlled Substances was reviewed. Under the section titled, Dispensing and Reconciling Controlled Substances, #7, it indicated Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 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** 50147 Based on observation, interview, and record review, the facility had a medication error rate of 7.69% when two medication errors occurred out of 26 opportunities during the medication administration for one out of six residents (Resident 18). The failures resulted in the nursing staff not following the facility's policy and procedures (P&P) and had the potential for the resident not receiving full therapeutic effects or causing side effects for the residents. Findings: 1. During the medication administration observation on 10/28/24 at 4:35 p.m., Registered Nurse 1 (RN1) was observed preparing and administering 3 medications to Resident 18: metformin (medication for diabetes) 500 milligrams (mg, unit of measurement) 1 tablet, calcium (a supplement) 500 mg 1 tablet, and brimonidine ophthalmic solution (medication for glaucoma) 0.15%. Resident was sitting up in her wheelchair. RN1 did not have the resident tilt her head back. With the resident's head/face looking straight ahead, RN1 instilled 1 drop of brimonidine ophthalmic solution in the right eye first, then repeated same action to the left eye. During the instillation of each drop, RN1 did not pull the lower eyelid down to instill into the conjunctival sacs. RN1 was observed wiping her right eye/cheek with a tissue as soon as the medication drop was instilled. He placed the tissue on the bedside table, and repeated the same action to her left eye. During an interview with RN1 on 10/28/24 at 4:38 p.m., when asked if he pulled the lower lids down before instilling each drop since her head was not tilted back, RN1 stated the resident tilted her head back a bit. He demonstrated how he used his fingers to widen the resident's upper & lower eyelids before instilling each drop. When the surveyor stated he was not observed pulling the resident's lower lid down or to make a pouch to instill into the conjunctival sac, RN1 stated he did not do either. He confirmed the resident's head was not tilted back, and he did not instill the drop into the conjunctival sac but directly onto the eye after widening it with his hand. A review of Resident 18's clinical record indicated a physician's order, dated 10/3/24, for brimonidine tartrate ophthalmic solution 0.15% Instill 1 drop in both eyes three times a day for Glaucoma. A review of the facility's undated P&P for Instillation of Eye Drops, indicated Step 7- Gently pull the lower eyelid down. Instruct the resident to look up. (If medical necessity gently pull upper and lower eyelid.), Step 8- Drop the medication into the mid lower eyelid (fornix) . 2. During the medication administration observation on 10/28/24 at 4:35 p.m., RN1 was also observed preparing and administering 1 tablet of metformin 500 mg to Resident 18. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN1 on 10/28/24 at 4:38 p.m., RN1 stated dinner is served at 5 pm. A review of the metformin Package Insert (manufacturer's information that includes details and directions that healthcare providers need [NAME] prescribe a drug properly, including approved uses for the drug, contraindications, potential adverse reactions, available formulations and dosage, and how to administer the drug), available online, with RN1 indicated to give metformin with meals. RN1 acknowledged Resident's 18 metformin was not administered with a meal. A review of Resident 18's clinical record indicated a physician's order dated 10/3/24, for metformin 500 mg, 1 tablet by mouth two times a day for diabetes. During another interview with RN1 on 10/28/24 at 5:08 p.m., 33 minutes after the metformin administration, the dinner cart was observed being wheeled to resident 18's hall. RN1 acknowledged Resident 18 had not had dinner yet at this time. During a telephone interview with the Consultant Pharmacist (CP) on 10/30/24 at 12:09 p.m.,, he stated metformin should be taken with meals which he explained is at the time of eating or shortly after. During an interview, on 10/28/24 at 2:22 p.m., with Director of Nursing (DON) and Assistant Director of Nursing (ADON), DON confirmed metformin should be given with meals. A review of the Package Insert for metformin, revised 3/2019, indicated, Metformin hydrochloride tablets should be taken with meals to help lessen an upset stomach side effect.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40478 Based on observation, interview and record review, the facility failed to store foods and maintain kitchen utensils in a sanitary manner. When: 1. An opened Thousand Island dressing container was found undated, and 2. A drawer with kitchen utensils was found to have bread crumbs on the floor of the drawer. These deficient practices will potentially have negative ill effect to the residents' health outcome, and a continous practice of cross contamination of kitchen utensils to food served to all residents in the facility. FINDINGS: 1. During an initial tour of the kitchen on 10/28/24 at 10:15 a.m., with the Dietary Manager (DM), and the Registered Dietitian (RD), an opened original plastic container of Thousand Island dressing with no open date was found on the top shelf of the produce refrigerator. It is about 1/3 full with spilled, dried and sticky yellowish/orangey dressing spill on the lid to the neck and shoulder of the container. Observed the DM removed the Thousand Island dresssing container from the refrigerator and looked for the label when the container was opened. The DM stated, this has no date, I can't find it. Will take this out. Observed a kitchen aide (KA1) came and started rearranging the items in the refrigerator. During an interview, KA1 stated, I am the one who labels and stock our supplies in the refrigerator. Yes, I do first in, first out. During a concurrent interview and observation with the RD, on where they placed the undated Thousand Island plastic container, she stated we discarded it here pointing at the large, round plastic garbage bin in front of the two sink. She instructed the DM to put on gloves to open the garbage bin lid to to show this Surveyor where the Thousand Island dressing container was. It was indeed inside that garbage bin. During a review of the facility's policy and procedure manual, Chapter 3: Food Production and Food safety (c) 2023, in item number 13, subtitled Refrigerated food storage: f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates or frozen (where applicable) or discarded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During a concurrent observation and interview on an initial tour of the kitchen on 10/28/24 at 10:25 a.m., with the Dietary Manager (DM), and the Registered Dietitian (RD), by the serving station in front of the stoves, observed a three layered drawers attached to the serving station. When the first drawer was opened, observed different colored scoops inside. The second drawer had serving utensils such as ladles in it. Observed tiny and fine crumbs on the drawer floor. The DM stated, those are bread crumbs from this, holding the bread toaster on top of the serving station. The DM instructed the cook (Cook1) to take all the utensils and wash them. The DM stated we will clean the drawer. Observed [NAME] 1 took all the utensils and proceeded to the washing sink. During a review of the facility's Policy and Procedure Manual 4-6 (a) May 18, 2017 titled General Sanitation of Kitchen, it indicated, Policy: Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Procedure: had 8 tasks including: cleaning schedule; task assignment; frequency of ckeaning; methods and materials of cleaning ; training, and so on. Resource: OSHA Quick Card. Hazard Communication Safety Data Sheets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38612 Based on observation, interview and record review, the facility failed to provide a safe and sanitary environment when an unlabeled basin containing exposed personal care items were kept on an overbed table in between the beds of Resident 6 and Resident 15. This failure had the potential to result in cross contamination and spread of infection in the facility. Findings: During an observation on 10/28/24 at 9:56 AM, an emesis basin (a shallow container used to catch fluids or debris from a patient) containing a tube of toothpaste, an exposed toothbrush, a packaged toothbrush, and a deodorant was found on an overbed table in between the beds of Resident 6 and Resident 15. During further observation on 10/28/24 at 10:48 AM, the kidney basin containing the aforementioned items was still on the overbed table in between the beds of Resident 6 and Resident 15. During a concurrent observation and interview on 10/28/24 at 10:52 AM, Certified Nursing Assistant (CNA) 1 stated, Not sure, when asked who the personal care items belong to. CNA 1 added, Not supposed to be there. I was going to change the old toothbrush, it's dirty. CNA 1 further stated the personal care items should be stored in the resident's drawer after use. During an interview on 10/30/24 at 9:33 AM, the Infection Preventionist stated, They (staff) are not supposed to leave it (personal care items) there. It's for safety. They (staff) might confuse it for somebody else, somebody else might use it. They (personal care items) should be in their (resident) drawer. Review of the facility's policy and procedure (P&P) titled, Teeth, Brushing (TB P&P), with a revision date of 2/2018, indicated Purpose - The purpose of this procedure is to assist the resident with oral hygiene. Preparation . 2. Assemble the equipment and supplies as needed .Steps in the Procedure - 1. Place the equipment on the bedside stand or overbed table. Arrange the supplies so they can easily be reached . After assisting the resident with oral hygiene, the TB P&P indicated 15. Clean your equipment. 16. Discard disposable equipment and supplies in designated containers . Review of the facility's P&P titled, Infection Prevention and Control Program, with a revision date of 12/2023, indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Elements of the IPCP .7. Prevention of Infection - a. Important facets of infection prevention include: . (3) educating staff and ensuring that they adhere to proper techniques and procedures .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 38612 Based on observation, interview, and record review, the facility failed to provide the required square footage per resident in multiple bedrooms for 17 out of 28 rooms (Rooms 101, 102,103, 104, 105, 106, 107, 108, 111, 115, 126, 127, 131, 132, 134, 136 and 139). This failure had the potential for inadequate usable space for the provision of residents' care and may impact their quality of life. Findings: Review of the facility's request for a waiver dated 3/2/24, indicated the following bedrooms failed to meet the requirement of 80 square feet per resident. Room Number Number of Beds in Room Square Feet Per Resident Square Feet Total 101 2 78.75 157.5 102 3 75 225 103 3 75 225 104 2 78.75 157.5 105 2 78.75 157.5 106 3 75 225 107 3 75 225 108 2 78.75 157.5 111 3 75 225 115 3 75 225 126 2 78.75 157.5 127 2 78.75 157.5 131 2 78.75 157.5 132 3 75 225 134 2 78.75 157.5 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055175	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawton Skilled Nursing & Rehabilitation Center	1575 7th Avenue San Francisco, CA 94122

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	136 3 75 225 139 2 78.75 157.5 During random observations and interviews of residents that occupied the above-mentioned rooms, during the survey, the residents expressed no concerns about quality of life, quality of care and safety related to the room space.