STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055271	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on interview, record review, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 (Resident #46 and Resident #69) of 17 sampled residents. Findings included: A facility policy titled, Resident Assessments, revised October 2023, revealed, 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. 1. An Admission Record revealed the facility Resident #46 on 08/12/2022. According to the Admission Record, the resident had a medical history that included diagnoses of hypertensive heart disease and heart failure. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/08/2024, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed the resident used a hearing aid. A quarterly MDS assessment, with an ARD of 08/08/2024, revealed that the resident had a BIMS score of 14, which indicated the resident had intact cognition. The MDS revealed the resident used a hearing aid. During an interview on 08/19/2024 at 11:12 AM, Resident #46 stated the facility was supposed to get them hearing aids but had not done it. During an interview on 08/22/2024 at 3:32 PM, the MDS Coordinator stated she was not aware the resident did not have hearing aids. During an interview on 08/23/2024 at 10:56 AM, Licensed Vocational Nurse #1 stated Resident #46 was hard of hearing and did not have hearing aids, but she knew the resident was in the process of getting hearing aids. During an interview on 08/23/2024 at 11:18 AM, Certified Nursing Assistant #11 stated Resident #46 did not have hearing aids. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/2024 at 2:21 PM, the Administrator stated he expected the MDS to be completed timely and accurately. During an interview on 08/23/2024 at 5:43 PM, the Director of Nursing (DON) stated she was responsible for ensuring the accuracy of the MDS. The DON stated the MDS should have indicated Resident #46 did not have hearing aids. 2. An Admission Record revealed the facility admitted Resident #69 on 05/27/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, hypertension, and polyneuropathy. A Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/31/2024, revealed Resident #69 discharged to a short-term general hospital on 05/31/2024. Resident #69's Progress Notes dated 05/31/2024 at 7:00 AM, revealed the resident left the faciity on [DATE] against medical advice (AMA). The Statement Releasing Facility from Liability when Resident Leaves AMA, dated 05/31/2024, revealed the form was signed by the resident on 05/31/2024 at 7:05 AM, which indicated the resident left the facility AMA. The Physician Discharge Summary, signed by a physician and dated 07/08/2024, revealed the resident discharged /Transferred to: AMA. During an interview on 08/23/2024 at 9:15 AM, the MDS Coordinator stated she did not know she selected the wrong discharge disposition for Resident #69. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated he expected the MDS to be completed timely and accurately. The Administrator stated accuracy was important and the disposition upon discharge for Resident #69 was an error. During an interview on 08/23/2024 at 5:43 PM, the Director of Nursing (DON) stated she was responsible for ensuring the accuracy of the MDS. The DON stated the MDS should be accurate for a resident's disposition at the time of discharge.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 45555 Based on interview, record review, and facility policy review, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASRR) was submitted for 1 (Resident #35) of 3 residents reviewed for PASRR. Findings included: During an interview on 08/22/2024 at 4:44 PM, Clinical Resource stated the facility did not have a policy for PASRR, but they followed the letter received from the State Department of Health Care Services dated 08/09/2023. The letter from the State Department of Health Care Services dated 08/09/2023, specified, Per Title 42 of the Code of Federal Regulations (C.F.R.) sections 483.100 through 483.138, individuals identified with a SMI [serious mental illness] and/or ID/DD/RC [intellectual disability/developmental disability/related conditions] must be screened and evaluated to determine whether SNF [skilled nursing facility] level of care and specialized services in the least restrictive setting that best meets their needs are required (PASRR Determination). All individuals, regardless of payer source, seeking admission to a Medicaid-certified SNF must have a PASRR Determination by the State Mental Health Authority [Department of Health Care Services (DHCS)] and/or ID/DD/RC Authority [Department of Developmental Services (DDS)] prior to SNF accepting admission. The letter revealed, The PASRR process begins with a preliminary screening (Level I Screening) to screen all individuals seeking admission to a Medicaid - certified SNF. If the Level I Screening returns a positive result for possible SMI and/or ID/DD/RC, a Level II Evaluation is performed by a Level II Evaluation Contractor (Level II Contractor). An Admission Record indicated the facility admitted Resident #35 on 07/25/2024. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, and anxiety disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident's diagnoses included depression and bipolar disorder. The MDS revealed the resident received antipsychotic and antidepressant medication during the assessment's lookback period. Resident #35's care plan included a focus area revised 08/06/2024, that indicated the resident used psychotropic medications for the management of active bipolar disorder. Interventions directed staff to administer medications as ordered, monitor, and document for side effects and effectiveness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35's Order Recap Report for orders from 07/25/2024 through 08/22/2024 revealed an order with a start date of 07/25/2024 and discontinued on 08/07/2024 for quetiapine fumarate (an antipsychotic) 50 milligrams (mg) by mouth one time a day for bipolar disorder. The Order Recap Report revealed an order dated 08/07/2024 for quetiapine fumarate 50 mg by mouth one time a day for bipolar disorder manifested by outbursts of verbal aggression towards staff and others. The Order Recap Report revealed an order with a start date of 07/25/2024 and discontinued on 08/07/2024 for venlafaxine hydrochloride (HCl) (an antidepressant) 75 mg by mouth two times a day for depression. The Order Recap Report revealed an order dated 08/07/2024 for venlafaxine HCl 75 mg by mouth two times a day for depression manifested by sad facial expressions as evidence by frowning/tearfulness. Resident #35's Preadmission Screening and Resident Review (PASRR) Level I Screening dated 07/25/2024 indicated the results of the Level I screening were negative for serious mental illness. Further review revealed the PASRR did not include the resident's diagnoses of bipolar disorder, major depressive disorder, or anxiety disorder and it did not indicate the resident received any psychotropic medications. During an interview on 08/20/2024 at 10:50 AM, the Social Service Director (SSD) stated the admissions department received the PASRR from the hospital when the resident was admitted to the facility, and they would review it for accuracy and then it was reviewed by the Assistant Director of Nursing (ADON) and Director of Nursing (DON). During an interview on 08/22/2024 at 3:13 PM, the Director of Business Development and Marketing stated she assisted with admissions and her only responsibility was to obtain the Level I PASRR prior to the resident admitting to the facility from the hospital. She stated the MDS Coordinator was responsible for reviewing the PASRR for accuracy. During an interview on 08/22/2024 at 3:19 PM, the MDS Coordinator stated the hospital would initiate the PASRR and then when the resident arrived at the facility, she was supposed to review the PASRR to ensure it was accurate and if it was not then they would need to resubmit the PASRR with the new information. The MDS coordinator stated she missed that Resident #35's Level I PASRR was not accurate. During an interview on 08/23/2024 at 1:17 PM, the DON stated that when a resident came from the hospital a Level I PASRR was completed before they got to the facility, and the admission person was responsible for verifying that it was accurate. She stated if the PASRR was not accurate then they would do a review. She stated they had a big problem with the hospitals related to PASRRs and she would have to redo the PASRRs so much that the individuals from the PASRR office were telling her that she was duplicating and needed to stop. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the admission team looked for and obtained the PASRR when the resident was admitting to the facility. The Administrator stated the accuracy of the PASRR should be reviewed by the interdisciplinary team (IDT) and if it was inaccurate then it should be resubmitted. He stated Resident #35's Level I PASRR should have been reviewed when it was received to verify the accuracy and it should have been resubmitted.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on observation, interview, record review, and facility policy review, the facility failed to revise 1 (Resident #15) of 17 sampled residents' comprehensive care plan. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. An Admission Record revealed the facility admitted Resident #15 on 03/09/2018. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a nontraumatic subarachnoid hemorrhage affecting the left nondominant side, flaccid hemiplegia affecting the left nondominant side, and contracted left hand. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2024, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #15's care plan included a focus area initiated 04/07/2018 and revised 03/08/2021, that indicated the resident had lymphedema to their bilateral lower legs. Interventions directed staff to apply pneumatic compression Flexitouch plus system to the resident's bilateral lower extremity for 45 minutes while in bed, initiated on 03/08/2021 and the resident was to have a [NAME] Hybrid Stocking and [NAME] wrap for compression to their bilateral lower extremities in the morning and remove on the night shift at the resident's bedtime every day and night shift for edema and could remove for activities of daily care. Resident #15's care plan included a focus area initiated 10/16/2018 and revised 10/25/2022, that indicated the resident had limited mobility to the left hand related to subarachnoid hemorrhage. Interventions directed the certified nurse assistant (CNA) to complete active range-of-motion (ROM) to the resident's left hand (imitated 10/16/2018). During a concurrent observation and interview on 08/19/2024 at 10:47 AM, Resident #15 stated they could not open their hand any further or bend their wrist at all. The surveyor noted the resident had significant contractures to their left wrist. During an interview on 08/21/2024 at 12:20 PM, Resident #15 stated they was supposed to have a brace for their left wrist and fingers, but they lost it, and therapy was supposed to get them a new one, but no one had yet. Resident #15 stated no one came in and did any type of exercises with them for their wrist or fingers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/2024 at 11:18 AM, CNA #11 stated she worked at the facility for three months and was familiar with Resident #15. CNA #11 stated she did not do any type of range-of-motion on Resident #15's arms when she cared for the resident and the resident did not have any type of brace. During an interview on 08/23/2024 at 1:25 PM, CNA #18 stated she did not perform ROM for Resident #15 due to the resident having contractures. According to CNA #18, there were prompts in a resident's electronic medical record for staff to document the provision of ROM; however, there no such ROM documentation for Resident #15. During an interview on 08/23/2024 at 1:35 PM, the MDS Coordinator stated the focus areas and interventions on Resident #15's care plan related to a brace, an assistive device, ROM, and compression stockings should be removed from Resident #15's care plan, as they were no longer relevant for the resident. During an interview on 08/23/2024 at 12:48 PM, the Director of Nursing stated the resident's care plan should be revised to reflect the current status of the resident. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated a resident's care should be revised when the status of the resident changed.

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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. 46659 Based on record review, interview, and facility policy review, the facility failed to provide fortified food intended for nutritional supplement for 1 (Resident #19) of 4 residents reviewed for nutrition. Findings included: A facility policy titled, Food and Nutrition Services, revised 10/2017, revealed, 1. The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. 2. A resident-centered diet and nutrition plan will be based on this assessment. An Admission Record revealed the facility admitted Resident #19 on 11/10/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of protein-calorie malnutrition. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2024, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated Resident #19 was on a mechanically altered diet. Resident #19's care plan included a focus area revised 05/15/2024, that indicated the resident had a nutritional risk related to hyperlipidemia, peripheral vascular disease, hypertension, chronic obstructive pulmonary disease, viral hepatitis C, atherosclerosis, chronic ischemic heart disease, history of malignant neoplasm of the glottis, mechanically altered diet, unspecified protein calorie malnutrition, and mood affective disorder. Interventions directed staff to provide the resident's diet as ordered. The care plan revealed the resident's diet was regular with mechanical soft/ground meat (revised 05/15/2024). Resident #19's Nutrition Assessment-V 1.5 dated 03/16/2024 revealed the Registered Dietician (RD) recommended to fortify the resident's diet order to provide additional energy intake and minimize the risks for further weight loss. A facility form titled Diet Communication, dated 03/28/2024 and completed by the Speech Language Pathologist (SLP), revealed Resident #19's diet was changed to easy to chew (mechanical soft) with thin liquids and additional nourishment of high protein/fortified. A facility document titled Order Details dated 03/28/2024 and created by the SLP, revealed Resident #19's diet was entered as regular diet, mechanical soft/ground meat with thin liquids. There was no documented evidence an order for high protein/fortified foods was entered. Resident #19's Order Summary Report with active orders as of 08/22/2024, contained an order, dated 03/28/2024, for a regular diet mechanical soft/ground meat texture with thin consistency. The Order Summary Report revealed no documented evidence high protein/fortified foods were ordered for the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2024 at 4:13 PM, the SLP stated she failed to put the high protein/fortified portion on the diet order for Resident #19. During an interview on 08/23/2024 at 9:00 AM, the Dietary Manager (DM) said that he did not know that Resident #19 was on a fortified/high protein diet, but that he should have caught that when the order was written back in March 2024. During an interview on 08/23/2024 at 2:22 PM, the Director of Nursing (DON) said she expected the staff to make sure the diet orders were entered as ordered and the residents received the correct diet. During an interview on 08/23/2024 at 2:34 PM, the Administrator said he expected staff to enter the diet orders in the system as ordered.

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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. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to provide proper monitoring during the administration of a nebulizer treatment for 1 (Resident #35) of 2 residents reviewed for respiratory care. Findings included: A facility policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised 10/2010, indicated, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The section titled Steps in the Procedure included 8. Dispense medication into nebulizer cup. 12. Turn on the nebulizer and check the outflow port for visible mist. 13. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask). 14. Instruct the resident to take a deep breath, pause briefly and then exhale normally. 15. Encourage the resident to repeat the above breathing patter until the medication is completely nebulized, or until the designated time of treatment has been reached. 16. Remain with the resident for the treatment. 17. Monitor for medication side effects, including restlessness and nervousness. 18. Tap the nebulizer cup occasionally to ensure the release of droplets from the side of the cup. 19. Encourage the resident to cough and expectorate as needed. 20. Administer therapy until medication is gone. 21. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece, and medication cup. 22. Wash and dry hands. An Admission Record indicated the facility admitted Resident #35 on 07/25/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, pneumonia, and shortness of breath. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2024, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had diagnoses that included pneumonia, and asthma, COPD, or chronic lung disease. Resident #35's care plan included a focus area revised 08/03/2024 that indicated the resident had COPD. Interventions directed staff to give aerosol or bronchodilators as ordered and monitor/document any side effects and effectiveness. Resident #35's Order Recap Report for orders from 07/25/2024 through 08/22/2024 revealed an order dated 07/25/2024 for ipratropium bromide inhalation solution 0.02 percent (%) 2.5 milliliters (ml) inhaled orally via nebulizer four times a day for COPD. Resident #35's Medication Administration Record [MAR] for August 2024, revealed a transcription of an order for ipratropium bromide inhalation solution 0.02% 2.5 ml via nebulizer that indicated the medication was to be administered at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/20/2024 at 2:03 PM, Resident #35 was sitting on the side of the bed. A nebulizer machine was on the nightstand with the mask and medication cannister in a plastic bag. There was a small amount of fluid noted in the cannister. During a concurrent interview Resident #35 stated they used the machine daily and staff took care of it, and they did not do anything with it. During an observation on 08/21/2024 at 12:30 PM, Resident #35's nebulizer machine was on the nightstand with the mask and medication cannister in a plastic bag. The medication cannister was over 3/4 full of fluid. During an observation on 08/22/2024 at 10:59 AM, Resident #35 was sitting on the side of the bed. The nebulizer machine was on the nightstand and the medication cannister was approximately 1/4 full of fluid. During an observation on 08/22/2024 at 12:05 PM, Resident #35 was lying on the bed waiting for lunch. The nebulizer machine medication cannister was approximately 1/4 full of fluid. During a concurrent interview Resident #35 stated they had not received a nebulizer treatment that day. During an observation on 08/22/2024 at 12:51 PM, a Licensed Vocational Nurse (LVN) entered Resident #35's room and put the nebulizer mask on Resident #35, started the nebulizer machine and walked out of the room. At 12:58 PM, the LVN entered the room and turned off the nebulizer machine and walked out of the room. There was a small amount of fluid left in the medication cannister. During an interview on 08/23/2024 at 8:54 AM, LVN #1 stated that when administering a nebulizer treatment, the nurse needed to stay with the resident until the medication was completely finished, which usually took about 15 minutes. During an interview on 08/23/2024 at 9:16 AM, LVN #2 stated when administering a nebulizer treatment, she would put the medication in the cannister and administer it. She stated it usually took 10 to 15 minutes, and the resident needed to be monitored during the treatment to ensure the machine was working, and that the resident was getting the whole treatment. She stated they were not to leave the room until the resident had taken all the medication. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated when the nurse was administering a nebulizer treatment, they should verify the need for the medication, assess the resident, ensure the equipment was not outdated and clean, and set the resident up and let them know what was going to happen to help keep them calm. She stated the nurse should put the medication in the cannister, put the mask on the resident, and stay with the resident to assess to see if the medication was effective. She stated the nurse should encourage the resident to cough and deep breathe and have them rinse their mouth post treatment. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the nurse should assess the resident prior to, during, and after administering a nebulizer medication and the nurse should stay with the resident and ensure that all the medication was administered.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49044 Based on interview and facility policy review, the facility failed to maintain copies of the posted direct care daily staffing numbers. This had the potential to affect all residents that resided in the facility. Findings included: A facility policy titled, Posting Direct Care Daily Staffing Numbers, revised in August 2022, revealed, Our facility will post on a daily basis for each shift nursing staff data, including the number of nursing personnel responsible for providing direct care to residents. The section titled Policy Interpretation and Implementation included 5. The previous shift's forms are maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it is forwarded to the office of the director of nursing services (DNS) and filed as a permanent record. 6. Records of staffing information for each shift are kept for a minimum of eighteen (18) months or as required by state law (whichever is greater). During an interview on 08/22/2024 at 2:46 PM, the Staffing Coordinator stated she was responsible for posting the daily staffing numbers. She stated she did not have the daily staffing postings for the timeframe from 07/23/2024 through 07/30/2024. She stated there was a glitch in their system and she was unable to input the numbers on the form they used. She stated she did handwrite the staffing numbers, but she did not keep the forms. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the daily staffing postings should be kept at least a year onsite for the facility's annual PPD (per patient day) review from the State. He stated the postings should be accurate, maintained together, and organized.

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	055271	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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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 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. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure prescribed medications were available for 2 (Resident #2 and Resident #29) of 5 residents reviewed for pharmacy services. Findings included: A facility policy titled, Medication Ordering and Receiving From Pharmacy, effective 04/2008, specified, Policy Medications and related products are received from the dispensing pharmacy on a timely basis. The section of the policy titled, A. Ordering Medications from the Dispensing Pharmacy specified, 2) If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form/ordered by peeling the bottom part of the pharmacy label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: a. Reorder medication five days in advance of need to assure an adequate supply is on hand. The policy also indicated, c. The refill order is called in, faxed, or otherwise transmitted to the pharmacy. 3) New medications, except for emergency or stat medications, are ordered as follows: a. If needed before the next regular delivery, inform pharmacy of the need for prompt delivery. b. The emergency kit or emergency drug supply as applicable is used when the resident needs a medication prior to pharmacy delivery. The policy also indicated, 6) New Admission/Re-admission Orders: a. When calling/faxing medication orders for a newly admitted resident, the pharmacy is also given all ancillary orders, allergies, and diagnoses to facilitate generation of a patient profile. The section of the policy titled, B. Receiving Medications from the Pharmacy specified, 1) A licensed nurse: a. Receives medications delivered to the facility and documents that the delivery was received and was secure on the medication delivery receipt. b. Verifies medications received and directions for use with the medication order form/and or physician's orders. c. Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor. d. Immediately delivers the medications to the appropriate secure storage area. e. Assures medications are incorporated into the resident's specific allocation prior to the next medication pass. 1. An Admission Record indicated the facility admitted Resident #2 on 05/24/2024. According to the Admission Record, the resident had a medical history that included diagnoses of hypertensive heart disease with heart failure and unspecified affective mood disorder. A 5-day scheduled Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/29/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #2's care plan included a focus area, initiated on 05/24/2024, that indicated the resident used antidepressant medication related to depression. An interventions dated 05/24/2024 directed staff to give antidepressant medications ordered by physician. Another focus area, initiated on 05/24/2024, indicated the resident had hypertension. An intervention, initiated on 05/24/2024 and revised on 05/31/2024, directed staff to give antihypertensive medications as ordered. Resident #2's physician's orders included the following orders: (continued on next page)

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LA Sierra Care Center	2424 M Street Merced, CA 95340

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an order started on 06/12/2024 for escitalopram oxalate (an antidepressant) 5 milligrams (mg), one tablet at bedtime; and - an order started on 05/25/2024 for prazosin 2 mg, one capsule at bedtime for hypertension. Resident #2's August 2024 Medication Administration Record (MAR) revealed on 08/19/2024, 08/20/2024, and 08/21/2024 the escitalopram and prazosin were coded as 10, which indicated Other. Per the MAR, on 08/22/2024, Registered Nurse (RN) #17 documented the resident's escitalopram was administered and documented the resident's prazosin as 1, which indicated Resident #2 refused the medication. Resident #2's Progress Notes revealed Medication Administration Notes, dated 08/20/2024 at 9:20 PM and 08/21/2024 at 8:20 PM that indicated Resident #2's prazosin and escitalopram were pending pharmacy delivery. During an interview on 08/23/2024 at 11:22 AM, Resident #2 stated they had not received all their medications the previous night and had not refused any of their medications. An observation on 08/23/2024 at 11:28 AM with Licensed Vocational Nurse (LVN) #1 revealed Resident #2's prazosin was not available on the medication cart, and a card of the resident's escitalopram tablets was with the overflow medications in the bottom drawer, with no tablets missing. During an interview on 08/23/2024 at 12:49 PM, RN #17 said when he administered medications to Resident #2 on the evening of 08/22/2024, the resident had a card with only one escitalopram tablet in it, which he administered to the resident. RN #17 said he could not explain why the other nurses documented the medication was not available. RN #17 further stated he called the pharmacy about the resident's prazosin and was told it would be delivered on 08/23/2024. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated, if a medication was not available on the medication cart, the nurse should contact the pharmacy to see when it would be delivered, contact the physician about the medication not being administered timely, document any new order received, and follow through with the order. The DON stated the medication could also be pulled from the emergency medication kit. The DON stated the nurses should continue to follow-up until the medication was received from the pharmacy. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated if a medication was not available, the nurse should notify the DON, the pharmacy, and the physician, and, based on what the physician recommended, they should contact the pharmacy and get the medication to the facility. The Administrator stated that once a medication was identified as not available, it should be followed up on until the medication was received from the pharmacy. The Administrator stated OTC medications could be obtained by central supply and, if not available, could be picked up at a local pharmacy. The Administrator stated the nurse should have followed up on the medications not being available for Resident #2. 2. An Admission Record indicated the facility admitted Resident #29 on 07/09/2024 and readmitted the resident on 07/22/2024 after a recent hospital stay from 07/14/2024 through 07/22/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified recurrent major depressive disorder. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/26/2024, revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #29's care plan included a focus area, initiated on 07/09/2024, that indicated the resident used clonazepam (a benzodiazepine) related to depression. An intervention dated 07/09/2024 directed staff to give antidepressant medications ordered by the physician. Resident #29's Order Recap Report, for the timeframe from 07/22/2024 through 08/31/2024, contained the following orders: - an order, started on 07/23/2024, for alpha-lipoic acid (a fatty acid) 100 milligrams (mg), one tablet one time a day for supplement. The report indicated the alpha-lipoic acid was on hold from 07/29/2024 through 08/05/2024 while awaiting delivery, and the order was discontinued on 08/09/2024; - an order, started on 07/23/2024, for clonazepam 1 mg, one tablet at bedtime related to major depressive disorder, recurrent, unspecified. The report indicated the clonazepam was discontinued on 07/30/2024 due to Resident #29's refusal of the order; and - an order, started on 07/23/2024, for FiberChoice (a prebiotic fiber supplement), two tablets one time a day for supplement. The report indicated the FiberChoice order was on hold from 07/26/2024 through 07/29/2024 while awaiting medication arrival, and the order was discontinued on 07/29/2024. Resident #29's July 2024 Medication Administration Record (MAR) revealed the resident's alpha-lipoic acid and clonazepam were coded 10 to indicate Other from 07/23/2024 through 07/29/2024. The MAR revealed the FiberChoice was coded 10 on 07/23/2024, 07/24/2024, 07/25/2024, and 07/29/2024, with documentation the order was held from 07/26/2024 through 07/28/2024. Resident #29's Progress Notes revealed Medication Administration Notes, dated 07/23/2024 at 9:00 PM, 07/24/2024 at 9:26 PM, 07/25/2024 at 9:04 PM, 07/26/2024 at 9:16 PM, 07/28/2024 at 10:01 PM, and 07/29/2024 at 9:32 PM, that indicated Resident #29's clonazepam was pending delivery. Resident #29's Progress Notes revealed a Medication Administration Note, dated 07/24/2024 at 9:29 AM, that indicated supply services were asked to order Resident #29's alpha-lipoic-acid. Resident #29's Progress Notes revealed a Medication Administration Note, dated 07/24/2024 at 9:30 AM, that indicated supply services were asked to order Resident #29's FiberChoice. Resident #29's Progress Notes revealed a Medication Administration Note, dated 07/25/2024 at 9:14 AM, that indicated the facility was awaiting on an in-house supply for Resident #29's alpha-lipoic acid. Resident #29's Progress Notes revealed a Medication Administration Note, dated 07/25/2024 at 9:15 AM, that indicated the facility was awaiting on Resident #29's FiberChoice. Resident #29's Progress Notes revealed Medication Administration Notes, dated 07/26/2024 at 10:21 AM, 07/27/2024 at 7:11 AM, 07/28/2024 at 7:50 AM, and 07/29/2024 at 10:02 AM, that indicated Resident #29's alpha-lipoic acid was not available and was pending delivery from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/23/2024 at 10:48 AM, Certified Nurse Assistant (CNA) #7 stated she was the central supply person that took care of over-the-counter (OTC) medications. CNA #7 stated, if she did not have an OTC medication in stock, she would let the nurse know that it was not on the formulary list and have the nurse contact the physician for something that was on the formulary list or order the medication from the pharmacy. CNA #7 stated she notified the nurse that Resident #29's FiberChoice was not on their formulary list and that they needed to contact the physician to get an alternative or order the specific medication from the pharmacy. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated, if a medication was not available on the medication cart, the nurse should contact the pharmacy to see when it would be delivered, contact the physician about the medication not being administered timely, document any new order received, and follow through with the order. The DON stated the medication could also be pulled from the emergency medication kit. The DON stated the nurses should continue to follow-up until the medication was received from the pharmacy. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated if a medication was not available, the nurse should notify the DON, the pharmacy, and the physician, and, based on what the physician recommended, they should contact the pharmacy and get the medication to the facility. The Administrator stated that once a medication was identified as not available, it should be followed up on until the medication was received from the pharmacy. The Administrator stated OTC medications could be obtained by central supply and, if not available, could be picked up at a local pharmacy. The Administrator stated the nurse should have followed up on the medications not being available for Resident #29.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than 5 percent (%). Observation of medication administration revealed the facility had 3 medication errors out of 28 total opportunities, resulting in a medication error rate of 10.71%, affecting 2 (Residents #9 and Resident #32) of 9 residents observed during medication administration. Findings included: A facility policy titled, Administering Medications, revised in 04/2019, specified, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy further specified, 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. 1. An Admission Record indicated the facility admitted Resident #9 on 10/13/2017. According to the Admission Record, the resident had a medical history that included a diagnosis of primary hypertension. Resident #9's Order Summary Report, listing active orders as of 08/22/2024, contained an order, dated 07/08/2024, for atenolol (an antihypertensive) 25 milligrams (mg) by mouth one time a day for hypertension with instructions to hold the medication if the resident's pulse was less than 60 beats per minute (BPM) or if their systolic blood pressure (SBP, the top number of a blood pressure value) was less than 110 millimeters of mercury (mmHg). On 08/20/2024 at 8:32 AM, Licensed Vocational Nurse (LVN) #12 entered Resident #9's room and obtained the resident's pulse, with a result of 84 BPM. LVN #12 then prepared and administered atenolol 25 mg to the resident without checking the resident's blood pressure. During an interview on 08/20/2024 at 8:56 AM, LVN #12 stated that when viewing atenolol on the resident's medication administration record, there was only a place to document the pulse, so she thought that was what the medication was primarily for; however, after reading the entire order, LVN #12 realized she should have also obtained the resident's blood pressure to know whether to hold the medication for a low SBP. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated the nurses should obtain all needed vital signs prior to administering medications. The DON stated if the vital signs were outside of the physician-ordered parameters, the nurses should hold the medication and notify the physician. She stated the nurses should read the full physician's order and follow any instructions for the medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the nurses should be following physician's orders and giving medications accordingly. He stated the nurses should read the medication orders in their entirety and all recommendation/special instructions should be followed, including obtaining a blood pressure and pulse if needed. 2. An Admission Record indicated the facility admitted Resident #32 on 02/10/2020. According to the Admission Record, the resident had a medical history that included diagnoses of chronic ischemic heart disease and primary hypertension. Resident #32's Order Summary Report, listing active orders as of 08/22/2024, contained an order, dated 05/04/2024, for lisinopril (an antihypertensive) 10 milligrams (mg) one time a day for hypertension. The order included instructions to hold the medication if the resident's pulse was less than 60 beats per minute (BPM), systolic blood pressure (SBP, the top number of a blood pressure value) was less than 110 millimeters of mercury (mmHg), or diastolic blood pressure (DBP, the bottom number of a blood pressure value) was less than 60 mmHg. Resident #32's Medication Administration Record [MAR] for August 2024 revealed transcription of an order, dated 05/04/2024, for lisinopril 10 mg with instructions to give 10 mg by mouth one time a day for hypertension and to hold if the resident's pulse was less than 60 BPM, SBP was less than 110 mmHg, or DBP was less than 60 mmHg. The MAR also revealed transcription of an order, dated 05/04/2024, for amlodipine besylate (an antihypertensive) 5 mg with instructions to give 5 mg by mouth one time a day for hypertension and to hold if the resident's pulse was less than 60 BPM, SBP was less than 110 mmHg, or DBP was less than 60 mmHg; the transcribed order had a discontinue date of 08/21/2024 at 10:02 AM. On 08/21/2024 at 7:58 AM, Licensed Vocational Nurse (LVN) #13 entered Resident #32's room and obtained the resident's blood pressure, with a result of 122/78 mmHg. LVN #13 then administered Resident #32's lisinopril and amlodipine without obtaining the resident's pulse. During an interview on 08/21/2024 at 8:44 AM, LVN #13 stated she only obtained Resident #32's blood pressure. After reviewing the orders for Resident #32, she stated she should have obtained the resident's pulse to determine whether the medications needed to be held. According to LVN #13, the resident's MAR only prompted staff to record a blood pressure. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated the nurses should obtain all needed vital signs prior to administering medications. The DON stated if the vital signs were outside of the physician-ordered parameters, the nurses should hold the medication and notify the physician. She stated the nurse should read the full physician's order and follow any instructions for the medications. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the nurses should be following physician's orders and giving medications accordingly. He stated the nurses should read the medication orders in their entirety and all recommendation/special instructions should be followed, including obtaining a blood pressure and pulse if needed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure 3 (Residents #9, #32, and #19) of 12 residents reviewed during medication administration and for unnecessary medication were free from significant medication errors. Specifically, the facility failed to ensure physician ordered vital signs were obtained prior to administering medications for Resident #9 and Resident #32 and failed to hold Resident #19's medications when their blood pressure and/or pulse were outside of physician-ordered parameters for administration. Findings included: A facility policy titled, Administering Medications, revised in 04/2019, specified, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy further specified, 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. 1. An Admission Record indicated the facility admitted Resident #9 on 10/13/2017. According to the Admission Record, the resident had a medical history that included diagnosis of primary hypertension. Resident #9's Order Summary Report, listing active orders as of 08/22/2024, contained an order, dated 07/08/2024, for atenolol (an antihypertensive) 25 milligrams (mg) by mouth one time a day for hypertension with instructions to hold the medication if the resident's pulse was less than 60 beats per minute (BPM) or if their systolic blood pressure (SBP, the top number of a blood pressure value) was less than 110 millimeters of mercury (mmHg). During an observation of medication administration 08/20/2024 at 8:32 AM, Licensed Vocational Nurse (LVN) #12 administered atenolol 25 mg to Resident #9 without checking the resident's blood pressure. Resident #9's Medication Administration Record [MAR] for August 2024 revealed staff documented atenolol was administered daily at 8:00 AM from 08/01/2024 through 08/10/2024, on 08/12/2024, 08/13/2024, and 08/15/2024 through 08/20/2024. The MAR revealed that prior to 08/21/2024, there was no documented evidence staff were monitoring the resident's blood pressure prior to the administration of the atenolol. During an interview on 08/20/2024 at 8:56 AM, Licensed Vocational Nurse (LVN) #12 stated that when she pulled up the order for atenolol for Resident #9 on the electronic MAR, there was only an option to document the resident's pulse. LVN #12 stated that she thought the atenolol was being administered to primarily treat the resident's pulse. LVN #12 stated that after reading the entire order she had realized that she should have taken the resident's blood pressure to know whether to hold the medication. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated the nurses should obtain all needed vital signs prior to administering medications. The DON stated if the vital signs were outside of the physician-ordered parameters, the nurses should hold the medication and notify the physician. She stated the nurses should read the full physician's order and follow any instructions for the medications. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the nurses should be following physician's orders and giving medications accordingly. He stated the nurses should read the medication orders in their entirety and all recommendation/special instructions should be followed, including obtaining a blood pressure and pulse if needed. 2. An Admission Record indicated the facility admitted Resident #32 on 02/10/2020. According to the Admission Record, the resident had a medical history that included diagnoses of primary hypertension and chronic ischemic heart disease. Resident #32's Order Summary Report, listing active orders as of 08/22/2024, contained an order, dated 05/04/2024, for lisinopril (an antihypertensive) 10 milligrams (mg) one time a day for hypertension. The order included instructions to hold the medication if the resident's pulse was less than 60 beats per minute (BPM), systolic blood pressure (SBP, the top number of a blood pressure value) was less than 110 millimeters of mercury (mmHg), or diastolic blood pressure (DBP, the bottom number of a blood pressure value) was less than 60 mmHg. Resident #32's Medication Administration Record [MAR] for August 2024 revealed a transcription of an order dated 05/04/2024 for lisinopril 10 mg with instructions to give 10 mg by mouth one time a day for hypertension and to hold if the resident's pulse was less than 60 BPM, SBP was less than 110 mmHg, or DBP was less than 60 mmHg. The MAR revealed a transcription of an order dated 05/04/2024 for amlodipine besylate (an antihypertensive) 5 mg with instructions to give 5 mg by mouth one time a day for hypertension and to hold if the resident's pulse was less than 60 BPM, SBP was less than 110 mmHg, or DBP was less than 60 mmHg; the transcribed order had a discontinue date of 08/21/2024 at 10:02 AM. The MAR revealed that prior to 08/22/2024 there was no documented evidence staff obtained the resident's pulse prior to administering the medications. During an observation of medication administration on 08/21/2024 at 7:58 AM, Licensed Vocational Nurse (LVN) #13 entered Resident #32's room and obtained the resident's blood pressure. LVN #13 then administered Resident #32's lisinopril and amlodipine without obtaining the resident's pulse. During an interview on 08/21/2024 at 8:44 AM, LVN #13 stated she only obtained Resident #32's blood pressure. After reviewing the orders for Resident #32, she stated she should have obtained the resident's pulse to determine whether the medications needed to be held. According to LVN #13, the resident's MAR only prompted staff to record a blood pressure. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated the nurses should obtain all needed vital signs prior to administering medications. The DON stated if the vital signs were outside of the physician-ordered parameters, the nurses should hold the medication and notify the physician. She stated the nurse should read the full physician's order and follow any instructions for the medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the nurses should be following physician's orders and giving medications accordingly. He stated the nurses should read the medication orders in their entirety and all recommendation/special instructions should be followed, including obtaining a blood pressure and pulse if needed. 46659 3. An Admission Record revealed the facility admitted Resident #19 on 11/10/2022. According to the Admission Record, the resident had a medical history that included diagnoses of hypertension and chronic ischemic heart disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2024, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated Resident #19 had active diagnoses of hypertension and chronic ischemic heart disease. Resident #19's care plan, included a focus area initiated on 05/25/2018 and revised on 05/15/2024 that indicated the resident had hypertension and chronic ischemic heart disease. Interventions directed staff to administer anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia), and monitor for effectiveness (initiated 05/25/2018). Resident #19's Medication Administration Record [MAR] for June 2024, July 2024, and August 2024 revealed the resident's physician orders were transcribed as follows: - diltiazem hydrochloride (HCL) 120 milligrams (mg), one tablet by mouth one time a day related to chronic ischemic heart disease. The MAR indicated the medication should be held if the resident's systolic blood pressure (SBP, the top number of a blood pressure value) was less than 110 millimeters of mercury (mmHg), diastolic blood pressure (DBP, the bottom number of a blood pressure value) was less than 65 mmHg, or the pulse was less than 60 beats per minute (BPM). The MARs indicated diltiazem was ordered on 05/04/2024, and according to the June 2024 and July 2024 MAR, the order was discontinued on 08/21/2024 at 10:13 AM. - metoprolol tartrate 25 mg tablet, one tablet by mouth two times a day for hypertension and to hold the medication for a SBP less than 110 mmHg, DBP less than 60 mmHg, or a pulse less than 60 BPM. The MAR revealed the medication was ordered on 05/04/2024 and according to the June 2024 and July 2024 MAR, the order was discontinued on 08/21/2024 at 10:13 AM. - hydrochlorothiazide 25 mg, one tablet by mouth two times a day for hypertension started on 05/04/2024. The MAR revealed hydrochlorothiazide should be held for a SBP less than 110 mmHg, DBP less than 60 mmHg, or pulse less than 60 BPM. Resident #19's MAR for June 2024 revealed staff documented that diltiazem was administered on 06/03/2024 at 8:00 AM, when the resident's DBP was 64 mmHg (less than the physician ordered parameter of 65 mmHg). The MAR also revealed staff documented that metoprolol tartrate and hydrochlorothiazide medications were administered on 06/26/2024 at 8:00 AM, when the resident's SBP was 108 mmHg (less than the physician ordered parameter of 110 mmHg). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #19's MAR for July 2024 revealed staff documented that diltiazem was administered on 07/09/2024 at 8:00 AM when the resident's DBP was 64 mmHg and on 07/14/2024 at 8:00 AM when the resident's DBP was 62 mmHg (less than the physician ordered parameter of 65 mmHg). The MAR revealed on 07/23/2024 at 5:00 PM staff documented that hydrochlorothiazide and metoprolol tartrate were administered even though the resident's pulse was 57 BPM (less than the physician ordered parameter of 60 BPM). Resident #19's MAR for August 2024 revealed staff documented diltiazem was administered on 08/08/2024 at 8:00 AM when the resident's SBP was 108 mmHg. Per the MAR, staff also documented that hydrochlorothiazide was administered on 08/08/2024 at 8:00 AM when the resident's SBP was 108 mmHg and metoprolol tartrate were administered on 08/02/2024 at 5:00 PM when the resident's SBP was 100 mmHg, and the pulse was 58; on 08/08/2024 at 8:00 AM when the resident's SBP was 108 mmHg; and on 08/08/2023 at 5:00 PM when the resident's SBP was 106 mmHg. Resident #19's Progress Notes for the timeframe from 06/01/2024 through 08/20/2024 revealed no documented evidence that the medications were held. During a phone interview on 08/23/2024 at 10:24 AM, Licensed Vocational Nurse (LVN) #4 stated that she was familiar with Resident #19's medication orders and was aware the resident's blood pressure and diuretic medications had parameters for administration. LVN #4 stated based on the documented vital signs, she should have held the resident's medications on 07/23/2024. During a phone interview on 08/23/2024 at 9:36 AM, LVN #16 stated she was aware of Resident #19's medication orders and she should have held the resident's medications on 08/02/2024 and on 08/08/2024. During an interview on 08/23/2024 at 9:01 AM, LVN #2 stated she had completed orientation in early 08/2024 and administered Resident #19's medications on 08/08/2024. She stated on 08/08/2024, she should have held Resident #19's diltiazem medication because the documented vital signs did not meet the physician ordered parameters. During an interview on 08/21/2024 at 3:04 PM, the Director of Nursing (DON) stated that if a medication had parameters, the staff should hold the medication if the vitals did not meet the ordered parameters. During a follow-up interview on 08/23/2024 at 1:17 PM, the DON stated she expected nurses to triple check and verify physician orders before administering medications. She said if a vital sign was outside the parameters the medication should be held. She stated it was very important to follow physician orders because the parameters were there to keep the resident safe. During an interview on 08/23/2024 at 2:14 PM, the Administrator stated he expected the nursing staff to follow the physician orders.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46659 Based on observation, interview, and facility document and policy review, the facility failed to provide palatable meals. This failure had the potential to affect all residents who received meals from the facility's kitchen. Findings included: A facility policy titled, Food and Nutrition Services, revised in 10/2017, revealed, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The policy also revealed, 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. During an interview on 08/19/2024 at 11:52 AM, Resident #29 complained that the facility's food was cold. According to a significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/26/2024, Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A menu titled, Week 4 Regular [facility name] CYCLE 2 2024 indicated that on 08/20/2024 the planned lunch meal included rosemary roast pork, noodles, and zucchini/tomatoes. During observations of the lunch meal service on 08/20/2024 from 12:22 PM to 12:44 PM, the cook was observed removing four to five plates from a plate warmer at one time to plate the food, then passing them to a dietary aide to cover them and place them on the tray cart. At 12:45 PM, the last tray cart left the kitchen, with a test tray also included. Prior to leaving the kitchen, the Dietary Manager (DM) checked the temperatures of the items on the test tray with the following results: rosemary roast pork -120 degrees, mashed potatoes -118 degrees (substituted for noodles), and zucchini/tomatoes - 138 degrees. The DM and surveyor followed the tray cart and observed as staff passed the trays out to the residents. The last resident tray was served at 1:05 PM, and the temperatures of the items on the test tray were checked with the following results: rosemary roast pork - 90 degrees, mashed potatoes -100 degrees, and zucchini/tomatoes -100 degrees. On 08/20/2024 at 1:08 PM, all surveyors tasted the food items on the test tray, and the food was found to be cold. The rosemary roast pork had no taste and was dry, the mashed potatoes had no taste, and the zucchini/tomatoes were overcooked, soggy, and had no flavor. 45555 During an interview on 08/20/2024 at 12:55 PM, Resident #29 stated they took one look at the lunch meal and could not eat it, so they asked for chicken noodle soup instead. During an interview on 08/20/2024 at 2:02 PM, Resident #58 stated the lunch was cold and the meat was dry but at least they got protein. According to an admission MDS, with an ARD of 06/27/2024, Resident #58 had a BIMS score of 13, which indicated the resident was cognitively intact. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49044 During a Resident Council Meeting held on 08/20/2024 at 2:22 PM, with eight residents in attendance, the residents reported the facility needed to add more seasoning to the food and reduce the amount spice used. The residents reported that the noodles served for the lunch meal on 08/20/2024 had no seasoning, and they could not tell what the vegetables were. The residents also reported the roast served for lunch was too peppery, and in general, the food was not warm enough. During an interview on 08/21/2024 at 12:20 PM, Resident #15 stated the food served for lunch on 08/20/2024 was awful. The resident said they thought they could get better food at a fast-food restaurant. Resident #15 said they could not tell what the vegetables served for lunch on 08/20/2024 were and said they tasted awful. According to a quarterly MDS, with an ARD of 05/29/2024, Resident #15 had a BIMS score of 15, which indicated the resident was cognitively intact. During an interview on 08/20/2024 at 12:19 PM, the DM stated he was aware of some complaints about food temperatures, but he thought the food left the kitchen at a reasonable temperature. He stated the staff were slow to pass out the meal trays, so the food could get could. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) said she expected the food to be at the right temperature when it left the kitchen and indicated she had spoken to the nursing staff regarding prompt distribution of the food. She also said she expected the food to look and taste good. During an interview on 08/23/2024 at 2:14 PM, the Administrator said he expected the kitchen to ensure cold foods were served cold and hot foods were served hot.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46659 Based on observation, interview, and facility document and policy review, the facility failed to ensure dietary staff did not document lunch meal service temperatures prior to placing the food items on the steam table for meal service and failed to ensure dietary staff utilized proper hand hygiene during meal service. These failures had the potential to affect all residents who received meals from the facility's kitchen. Findings included: A facility policy titled, Food Preparation and Service, revised 10/2017, revealed, Food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices. The policy also indicated, 5. Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. The policy also indicated, 6. Bare hand contact with food is prohibited. Gloves must be worn when handling food directly. However, gloves can also become contaminated and/or soiled and must be changed between tasks. 1. During an initial tour of the facility's kitchen, on 08/19/2024 at 9:40 AM, the meal service temperature logs were requested from the Dietary Manager (DM). On 08/19/2024 at 9:45 AM, the Food Temperature Logs were provided. The Food Temperature Log, dated 08/19/2024, contained both breakfast and lunch food item temperatures, despite the lunch meal having not yet been placed onto the steam table for meal service. During an interview on 08/19/2024 at 10:03 AM, the DM stated staff documenting meal service temperatures in advance was unacceptable. He indicated meal service temperatures should only be taken when the food was placed on the steam table. During an interview on 08/20/2024 at 1:50 PM, Dietary Staff #14 said meal service temperatures should be taken when food is placed on the steam table, not prior. During a phone interview on 08/22/2024 at 5:38 PM, Dietary Staff #15 stated she had worked at the facility for many years, and she knew what the temperatures of items on the steam table would be, which is why she filled out the lunch meal temperatures early on 08/19/2024. Dietary Staff #15 said she knew that meal service temperatures were to be documented on the temperature logs as the food was placed on the steam table, not prior; she stated she also knew not to guess on what the temperatures would be. Dietary Staff #15 said she knew it was very important to have accurate temperatures documented on the logs so that the residents would get food at the correct temperatures and to make sure the steam table was keeping the food at an acceptable temperature. During an interview on 08/23/2024 at 2:14 PM, the Administrator stated the meal service temperatures should not be taken in advance and should be done accurately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an observation on 08/20/2024 at 12:25 PM, Dietary Staff #14 was observed wearing gloves in the kitchen while opening boxes and touching surfaces. Dietary Staff #14 then prepared a grilled cheese sandwich without changing her gloves. At 12:30 PM, while preparing the grilled cheese sandwich, Dietary Staff #14 pulled at the waist of her pants and pulled her shirt down with one of her gloved hands, then proceeded to prepare another grilled cheese sandwich without changing gloves or washing her hands. During an interview on 08/20/2024 at 1:50 PM, Dietary Staff #14 said she should have changed her gloves after she touched her clothing while preparing the grilled cheese sandwiches. During an interview on 08/20/2024 at 2:14 PM, the Dietary Manager (DM) said he expected dietary staff to change gloves as needed, especially if they touched their clothes or touched a garbage can lid. During an interview on 08/23/2024 at 1:17 PM, the Director of Nursing (DON) stated she expected the staff not to touch their clothing and then touch food. During an interview on 08/23/2024 at 2:14 PM, the Administrator stated he expected staff to change their gloves when they touched other items, such as their clothes or if they changed tasks.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45555 Based on interview and record review, the facility failed to ensure physician orders for vital signs were transcribed to medication administration records for 2 (Resident #9 and Resident #32) of 9 residents observed during medication administration. Findings included: 1. An Admission Record indicated the facility admitted Resident #9 on 10/13/2017. According to the Admission Record, the resident had a medical history that included a diagnosis of primary hypertension. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2024, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #9's care plan included a focus area revised 01/30/2018 that indicated the resident had hypertension. Interventions directed staff to administer atenolol, an antihypertensive medication, as ordered by the physician to monitor for side effects such as orthostatic hypotension and increased heart rate (revised 06/10/2020), and to hold the atenolol if the resident's systolic blood pressure (SBP, the top number of a blood pressure value) was less than 110 millimeters of mercury (mmHg) or the diastolic blood pressure (DBP, the bottom number of a blood pressure value) was less than 60 mmHg (revised 02/27/2024). Resident #9's Order Summary Report for active orders as of 08/22/2024 indicated the resident had an order dated 07/08/2024 for atenolol (an antihypertensive) 25 milligrams (mg) by mouth one time a day for hypertension with instruction to hold the medication if the resident's pulse was less than 60 beats per minute (BPM) or if the SBP was less than 110 mmHg. Resident #9's Medication Administration Record [MAR] for August 2024 revealed staff were monitoring the resident's pulse. However, prior to 08/21/2024, there was no documented evidence staff were monitoring the resident's blood pressure prior to the administration of the atenolol. During an interview on 08/20/2024 at 8:56 AM, Licensed Vocational Nurse (LVN) #12 stated that when she pulled up the order for atenolol for Resident #9 on the electronic MAR, there was only an option to document the resident's pulse. LVN #12 stated that she thought the atenolol was being administered to primarily treat the resident's pulse. LVN #12 stated that after reading the entire order she had realized that she should have taken the resident's blood pressure to know whether to hold the medication. 2. An Admission Record indicated the facility admitted Resident #32 on 02/10/2020. According to the Admission Record, the resident had a medical history that included diagnoses of primary hypertension and chronic ischemic heart disease. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/18/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #32's Order Summary Report, listing active orders as of 08/22/2024, contained an order dated 05/04/2024 for lisinopril (an antihypertensive) 10 milligrams (mg) one time a day for hypertension. The order included instructions to hold the medication if the resident's pulse was less than 60 beats per minute (BMP), systolic blood pressure (SBP, the top number of a blood pressure value) was less than 110 millimeters of mercury (mmHg), and diastolic blood pressure (DBP, the bottom number of a blood pressure value) was less than 60 mmHg. Resident #32's Medication Administration Record [MAR] for August 2024 revealed a transcription of an order dated 05/04/2024 for lisinopril 10 mg with instructions to give 10 mg by mouth one time a day for hypertension and to hold if the resident's pulse was less than 60 BMP, SBP was less than 110 mmHg, and DBP was less than 60 mmHg. The MAR revealed a transcription of an order dated 05/04/2024 for amlodipine besylate (an antihypertensive) 5 mg with instructions to give 5 mg by mouth one time a day for hypertension and hold is the resident's pulse was less than 60 BMP, SBP was less than 110 mmHg, and DBP was less than 60 mmHg; the transcribed order had a discontinue date of 08/21/2024 at 10:02 AM. The MAR revealed that prior to 08/22/2024 there was no documentation of the resident's pulse. The MAR revealed that Licensed Vocational Nurse (LVN) #13 had documented that she administered Resident #32's 8:00 AM dose of lisinopril and amlodipine on 08/21/2024. During an interview on 08/21/2024 at 8:44 AM, LVN #13 stated that she obtained the resident's blood pressure only and no other vitals, including the resident's pulse. After reviewing the orders for Resident #32, she stated she should have obtained the pulse to see if the medication needed to be held due to the pulse being low, not just the blood pressure. She stated the MAR only prompted staff to record the blood pressure, so she thought that was all she needed. She stated she should have read the order completely and contacted the physician for clarification and corrected the MAR to include the need for the resident's pulse reading.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on observation, interview, document review, and facility policy review, the facility failed to ensure residents' rooms measured at least 80 square (sq) feet (ft) per resident in 19 (Rooms 1 through 7, Rooms 10 through 20, and room [ROOM NUMBER]) of 23 resident rooms in the facility. Findings included: A facility policy titled Bedrooms revised 05/2017, revealed, All residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. The policy revealed, 2. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms. The Client Accommodations Analysis, signed by the Maintenance Supervisor (MS) and dated 08/20/2024, revealed the following: - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 70 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 77.3 sq ft for each resident - In room [ROOM NUMBER], there was 72 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 76 sq ft for each resident - In room [ROOM NUMBER], there was 75 sq ft for each resident - In room [ROOM NUMBER], there was 78 sq ft for each resident - In room [ROOM NUMBER], there was 72.3 sq ft for each resident (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- In room [ROOM NUMBER], there was 74.6 sq ft for each resident - In room [ROOM NUMBER], there was 73.3 sq ft for each resident - In room [ROOM NUMBER], there was 75 sq ft for each resident - In room [ROOM NUMBER], there was 71.6 sq ft for each resident During an interview on 08/23/2024 at 10:52 AM, the MS stated he had been MS since April 2023. The MS stated the facility had waivers for some of the rooms because the rooms did not meet the allotted square footage per resident The MS stated he did not have any concerns brought to him about the sizes of the rooms, neither from staff nor from residents. During an interview on 08/23/2024 at 12:48 PM, the Director of Nursing stated she had not heard of any complaints about the sizes of the rooms. During an interview on 08/23/2024 at 2:21 PM, the Administrator stated the size of the resident rooms did not impede on other residents. The Administrator stated as long as the residents were comfortable and could move and staff could treat and provide care to the residents, he did not have any issues with it. Per the Administrator, no one voiced any complaints to him about the size of resident rooms.