STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055322	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	3202 Duke Street San Diego, CA 92110

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record reviews, the facility failed to obtain an informed consent for one of three sampled residents (18), reviewed for unnecessary medication. This failure had the potential for the resident to not be aware of the risks and benefits of taking psychotropic (chemicals which altered brain function) medications. FINDINGS: A record review of Resident 18's Admission Record indicated that Resident 18 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thought, mood, and behavior) and major depressive disorder (characterized by low mood and low self-esteem). A review of Resident 18's Physician's orders indicated the following: .Clonazepam (anxiety medication) 0.25 milligram (mg- unit of measurement) po (by mouth) twice a day - Dx (diagnosis). Anxiety (repeated episodes of sudden feelings of intense fear & worry) . .Valproic acid (medication to treat mental disorders) 20 millimeters (ml-unit of measurement) po three times a day - Dx. Schizophrenia (a disconnection from reality) . .Olanzapine (medication to treat mental disorders) 2.5 mg po four times a day- Dx. Schizophrenia . A concurrent interview and record review on 10/23/24 at 9:36 A.M., with Licensed Nurse (LN) 1 was conducted. LN 1 stated they did not have the consents for the following psychotropic medications: valproic acid, clonazepam, and olanzapine. A record review of Resident 18's Admission Record, dated 7/8/24, indicated Resident 18 was under conservatorship (not able to make his/her own decisions). A review of Resident 18's History and Physical Record, dated 7/10/24, indicated Resident 18 could make his/her needs known but could not make medical decisions. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent interview and record review on 10/23/24 at 1:12 PM., with Medical Records (MR) was conducted. MR stated, I don't see any consents for those medications (clonazepam, valproic acid, and olanzapine), they were not in the chart or [Resident 18's] medical record. An interview on 10/24/24 at 9:15 A.M., with the Director of Nursing (DON) was conducted. The DON stated informed consent should have been obtained before Resident 18 started taking any psychotropic medications. The DON stated it was important to have informed consent so Resident 18's family or responsible party (decision maker) was aware of what medications Resident 18 was taking. The DON acknowledged there were no consents for the use of psychotropic medications in Resident 18's medical record. A review of the facility's undated Policy on Behavior/ Psychoactive Drug Management indicated, .Procedure . C. Whenever an order is obtained for psychoactive medication(s), the licensed nurse verifies with the attending physician that informed consent has been obtained. The licensed nurse documents verification of the order .D. The licensed nurse will contact the resident and/ or responsible party and verify .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39449 Based on interview and record review, the facility failed to ensure one of two sampled residents (221) had a POLST (physician orders for life sustaining treatment, end of life wishes) signed by the Responsible Party (RP). As a result, there was a potential to not have the resident's end of life wishes honored. Findings: Resident 221 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, per Resident 221's Admission Record. A review of Resident 221's History and Physical Examination, dated 10/4/24, indicated physician marked, . does NOT have the capacity to understand and make decisions . A review of the POLST, dated 10/5/24, indicated it was signed by the physician on 10/5/24. The section for Signature of Patient or Legally Recognized Decision Maker had a box titled, Signature (required) which was left uncompleted. On 10/23/24 at 10:48 A.M., an interview and record review was conducted with Licensed Nurse (LN) 31. LN 31 stated the POLST should have been signed for Resident 221. LN 31 stated Resident 221's preferences should have been honored. LN 31 stated the admitting LN and LNs should have been responsible for making sure the POLST was completed by the physician and the resident or the resident's RP. On 10/24/24 at 12:30 P.M., an interview and record review was conducted with the Director of Nursing (DON). The DON stated the POLST should have been signed and completed within 24 hours so the facility would know the code status of Resident 221. The DON acknowledged Resident 221's POLST should have been completed to make sure the facility was honoring Resident 221's wishes. Per the facility policy, titled Physician Orders for Life-Sustaining Treatment (POLST), revised 6/3/20, . Purpose . To help ensure that the facility honors residents' treatment wishes concerning resuscitation and life-sustaining treatment .Procedure .I. General Information on POLST Forms .A. A completed and signed POLST is a legal physician order that is immediately actionable .III. Initiating a POLST .A. Only the attending physician .may complete the POLST form .D. The POLST form must be completed, signed and dated, include the practitioner's medical license number and be signed by the resident, resident's representative or the resident's health care decision maker .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on observation, interview, and record review, the facility failed to provide a homelike environment for one of six sampled residents (108) when there was a large opening observed in the wall under the sink. This failure had the potential for the resident to feel uncomfortable in their environment. Findings: Resident 108 was admitted to the facility on [DATE] with diagnoses including muscle weakness and other abnormalities of gait (walking) and mobility per the Admission Record. Resident 108 was cognitively intact (aware of surroundings) based the resident's Minimum Data Set (MDS, an assessment tool), dated 9/10/24. A concurrent interview and observation was conducted with Resident 108 in Resident 108's room on 10/21/24 at 9:03 A.M. Resident 108 stated she would like to complain about the sink in her bathroom. She stated she feared the sink would fall. A large hole on the wall beneath the sink was observed. The hole spanned the length of the sink. A concurrent interview and observation was conducted with Licensed Nurse (LN) 21 on 10/21/24 at 10:29 A.M., in Resident 108's bathroom. LN 21 wiggled the sink up and down resulting in a piece of plaster falling off from the wall under the sink. LN 21 stated the sink did not look safe. A concurrent interview and record review was conducted with the Maintenance Assistant (MA) and Maintenance Director (MD) at the nurse's station on 10/21/24 at 10:39 A.M. The MA stated the maintenance log indicated sink falling off wall was reported on 8/5/24 in Resident 108's bathroom. The MA stated he initialed (with one's initials in order to authorize or validate) the problem as resolved because he placed a seal around the sink. The MD stated that having a hole in the wall under the sink was not aesthetically pleasing, and needed to be fixed. An interview was conducted with Resident 108 on 10/23/24 at 10:23 A.M. in Resident 108's room. Resident 108 stated she would not have an open wall in her own home. Resident 108 stated it did not look good. A review of the facility's policy titled Resident Rights - Personal Property, revised 1/1/12, indicated .Purpose: To ensure the quality of life of all residents by allowing residents to create a home-like environment .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to provide a written notice of discharge to one of three sampled discharged residents (109). As a result, Resident 109 was not fully informed of his discharge. Findings: Per the facility's Face Sheet, Resident 109 was admitted to the facility on [DATE] with diagnoses which included cirrhosis of the liver (liver failure). On 10/23/24 at 2:10 P.M., a review of Resident 109's medical record was conducted. On 10/16/24 there was a physician's order to transfer Resident 109 to an acute care hospital. The 10/16/24 Progress Notes did not include any documentation of the staff providing a written notice of discharge to Resident 109. On 10/23/24 at 2:16 P.M., an interview was conducted with Licensed Nurse (LN) 1 and LN 2. LN 1 and LN 2 stated that they both coordinated Resident 109's discharge to an acute care hospital. LN 2 stated she was not familiar with the written notice of discharge form. LN 1 stated they did not provide the written notice of discharge to Resident 109 at the time of discharge. On 10/24/24 at 10:17 A.M., an interview was conducted with the Director of Nursing (DON). The DON acknowledged that the nurse should have provided Resident 109 with a notice of discharge when the resident was transferred to an acute care hospital. Per the facility's policy, titled Discharge and Transfer of Residents, revised 12/21/23, .Prior to discharge, the Facility will provide the resident/ resident representative with the Notice of Proposed Transfer and Discharge document .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to provide a written notice of the facility's bed-hold policy at the time of discharge to one of three sampled discharged residents (109). As a result, Resident 109 was not fully informed of his bed-hold rights. Findings: Per the facility's Face Sheet, Resident 109 was admitted to the facility on [DATE] with diagnoses which included cirrhosis of the liver (liver failure). On 10/23/24 at 2:10 P.M., a review of Resident 109's medical record was conducted. On 10/16/24 there was a physician's order to transfer Resident 109 to an acute care hospital. The 10/16/24 Progress Notes did not include any documentation of the staff providing a written notice of bed-hold to Resident 109. On 10/23/24 at 2:16 P.M., an interview was conducted with Licensed Nurse (LN) 1 and LN 2. LN 1 and LN 2 stated that they both coordinated Resident 109's discharge to an acute care hospital. LN 1 stated they did not provide a written notice of bed-hold to Resident 109 at the time of discharge. On 10/24/24 at 10:17 A.M., an interview was conducted with the Director of Nursing (DON). The DON acknowledged that the nurse should have provided Resident 109 with a copy of the bed-hold form when the resident was transferred to an acute care hospital. Per the facility's policy, titled Bed Hold, revised July 2017, .The Facility notifies the resident and/or representative, in writing, of the bed hold, option, any time the resident is transferred to an acute care hospital .The Licensed Nurse .will document that the resident and/or representative was notified of the option to hold the bed on the Notification of Bed Hold .

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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** 39448 Based on interview and record review, the facility failed to ensure medication was properly documented in the Minimum Data Set (MDS, resident assessment tool), for one of 24 sampled residents (88). As a result, medical decisions based on the MDS had an increased risk for error. Findings: Per the facility's Admission Record, Resident 88 was admitted to the facility on [DATE]. Per the facility's MDS, dated [DATE], Section N - Medications, Resident 88 received one insulin (a medication to control blood sugar) injection over the previous seven days. A review of Resident 88's medical record was conducted. Resident 88's record did not include any orders for insulin. On 10/23/24 at 10:59 A.M., an interview was conducted with the MDS coordinator (MDS 21). MDS 21 stated that he reviewed Resident 88's medical record and could not find orders for insulin. MDS 21 further stated that he marked Resident 88's MDS in error when he documented that she was receiving insulin. Per the facility's policy, titled RAI (Resident Assessment Instrument) process, revised 10/4/16, .The facility will utilize the Resident Assessment Instrument .process as the basis for the accurate assessment of each resident's functional capacity and health status .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on interview and record review, the facility failed to complete the PASARR (Preadmission Screening and Resident Review, a federal requirement to help ensure individuals are not inappropriately placed in a nursing facility) II in a timely manner for one of three residents (67)sampled for PASARR. This failure had the potential to result in Resident 67's mental health needs to be unmet. Findings: Resident 67 was initially admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental health disorder causing hallucinations, delusions, and mood changes), major depressive disorder (a mental health condition characterized with low or loss of interest in things that once brought joy), and generalized anxiety disorder (a mental disorder characterized by excessive worry about everyday events) per the Admission Record. A concurrent interview and record review was conducted with the Director of Nursing (DON) on 10/24/24 at 8:58 A.M. The DON stated the PASARR II for Resident 67 was not completed, per a letter from the Department of Health Care Services (HCS), dated 3/10/24. The letter indicated .the individual as unable to participate in the Evaluation . The DON stated it should have been followed up by the MDS Coordinator (MDS 21) as Resident 67 had a serious mental illness and the PASARR I, dated 3/8/24, indicated suspected mental illness (MI). The letter from HCS indicated .if MI is suspected, then a Level II Mental Health Evaluation may be conducted to determine if the individual can benefit from specialized mental health services . A telephone interview with the MDS consultant (MDS 22) was conducted, along with MDS 21, on 10/24/24 at 10:57 A.M. MDS 22 stated that completion of the PASARR was important for the placement of the resident and making sure there was a correct referral for mental health services. A joint interview and record review was conducted with MDS 21 on 10/24/24 at 11:08 A.M. MDS 21 stated the PASARR II was not completed because the letter subject indicated unable to complete level II evaluation. MDS 21 stated there were no other PASARR reviews conducted after 3/10/24. MDS 21 stated he should have followed up with HCS. A review of the facility's policy titled Admission Screening Resident Review (PASRR), revised 9/1/23, indicated .the Facility MDS Coordinator will be responsible to access and ensure updates to the PASRR are completed .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record review, the facility failed to ensure a care plan was developed for psychotropic medication (chemical that alters the brain) for two (47, 105) of five residents reviewed for care plan implementation. This failure had the potential for Residents 47 and 105 's current psychotropic drug monitoring to not be communicated to all health care providers. Findings. 1) A review of Resident 47's Admission Record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included Vascular Dementia (problems with reasoning, planning, judgement, memory, and other thought process) and Major Depressive Disorder (a serious mental disorder that affects how a person feels, thinks, and acts). An interview and record review on 10/23/24 at 9:27 A.M., with Licensed Nurse (LN) 1 was conducted. LN 1 stated Resident 47 was on Seroquel (medication to treat mental disorder) 12.5 milligram (mg- metric unit of measurement) at bedtime. LN 1 stated there was no care plan for the Seroquel with the diagnosis of Vascular dementia. 2) A review of Resident 105's Admission Record indicated Resident 105 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder. A review of Resident 105 's Physicians order indicated that Resident 105 was on the following psychotropic medications: [lorazepam] (medication for mental disorder) 0.5 mg via Gastrostomy tube (GT-a feeding tube inserted through the stomach) every four hours as needed for anxiety. Citalopram (medication for mental disorder) 10 mg via GT daily - for depression. An interview on 10/23/24 at 9:27 A.M., with LN 1 was conducted. LN 1 stated there was no care plan for Resident 105's lorazepam or citalopram. LN 1 stated a care plan was important for staff when caring for Resident 105. LN 1 stated that a care plan acts as a communication for all healthcare providers. An interview on 10/23/24 at 10:30 A.M., with the Director of Nursing (DON) was conducted. The DON stated a care plan was important to individualize resident care needs and to communicate to staff the specific interventions a resident required. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy, dated 8/24/23, on Comprehensive Person -Centered Care Planning indicated . c. the baseline care plan will be developed within 48 hours of admission .d. since the baseline care plan is developed before the comprehensive care plan, a change in resident goals, physical, mental and psychological functioning not previously identified, must be specific and incorporated .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39449 Based on observation, interview and record review, the facility failed to provide routine nail care to one of three residents (91) reviewed for Activities of Daily Living (ADL, activities related to personal care) for dependent residents. As a result, Resident 91 was at risk for skin injury and infection. Findings: Resident 91 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke, loss of blood flow to a part of the brain), ataxia (lack of muscle coordination and control) and reduced mobility, per the facility's Admission Record. A review of the History and Physical Examination, dated 7/6/23, indicated diagnosis included muscle weakness and has the capacity to understand and make decisions . On 10/21/24 at 10:52 A.M., an observation and interview was conducted with Resident 91. Resident 91 was lying on his bed. Resident 91's fingernails were long with yellowish discoloration. Resident 91 stated he wanted his fingernails cut. On 10/22/24 at 3 P.M., an observation and interview was conducted with Restorative Nursing Assistant (RNA) 31. RNA 31 stated Resident 91 was capable of understanding but he is slow because of brain injury but he can answer. RNA 31 stated Resident 91 needed assistance with his personal care. On 10/24/24 at 8:48 A.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 32. CNA 32 stated Resident 91 was somewhat alert but very dependent. CNA 32 stated Resident 32 do not communicate his needs and CNAs should initiate asking what he needed. CNA 32 stated CNAs could cut fingernails or file residents' fingernails. On 10/24/24 at 8:57 A.M., a concurrent observation and interview was conducted with Licensed Nurse (LN) 31 and CNA 32. LN 31 and CNA 32 observed Resident 91's long and yellowish fingernails on both hands. LN 31 stated resident fingernails could be cut by CNAs. LN 31 stated Resident 91's long fingernails should have been cut for cleanliness. LN 31 stated Resident 91's long fingernails on both hands should have been cut to prevent germ build up and to prevent contamination when Resident 91 touched his face and mouth. On 10/24/24 at 12:37 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated CNAs and LNs could have cut resident fingernails. The DON stated LNs should have overseen care plans for resident nail care. The DON acknowledged Resident 91's long fingernails on both hands should have been cut for upkeep and hygiene. Per the facility policy, titled Grooming, revised 1/1/12, .Purpose .To promote hygiene, comfort, self-esteem and dignity for resident through improving their ability to dress themselves .Procedure .I. Self-grooming activities include .taking care of fingernails and toenails .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to ensure medication was delivered from the pharmacy in a timely manner for one of 24 sampled residents (88). As a result, Resident 88 did not receive ropinirole (a medication to treat restless leg syndrome [uncomfortable legs]) as ordered for three days. Findings: Per the facility's Admission Record, Resident 88 was admitted to the facility on [DATE] with diagnoses which included chronic pain. Per the facility's Medication Administration Record (MAR), dated 10/23/24, Resident 88 had an order to have/take ropinirole two times per day for restless leg syndrome. On October 1st, 2nd, and 3rd, the medication was marked as not administered. Per the facility's Progress Notes, there was a note dated 10/1/24 at 6:10 A.M., by Licensed Nurse (LN) 11, that read, .med (medication) not available . The progress note did not indicate if the medication was reordered from the pharmacy. Per the facility's Progress Notes, there was a note dated 10/2/24 at 5:02 A.M., that read, .med not available . The progress note did not indicate if the medication was reordered from the pharmacy. Per the facility's Progress Notes, there was a note dated 10/3/24 at 6:25 A.M., that read, .med unavailable waiting for delivery . The progress note did not indicate if the medication was reordered from the pharmacy. LN 11 was not available for interview. On 10/24/24 at 10:13 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, when a LN was unable to find Resident 88's ropinirole in the medication cart, they should have called the pharmacy to have them send out the medication the same day, and documented the call. A review of the facility's policy, titled Medication Ordering and Receiving From Pharmacy, dated April 2008 was conducted. The policy did not include directions on reordering medication from the pharmacy, or reordering medication before medications ran out/are used up.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	3202 Duke Street San Diego, CA 92110

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on interview and record review, the facility failed to ensure two of three residents (47, 105) reviewed for psychotropics (a drug or other substance that affects how the brain works) had specific behavior monitoring in place for the use of psychotropic medications. This failure placed Resident 47 and Resident 105 at an increased risk of receiving unnecessary psychotropic medications. Findings: 1. A review of Resident 47's Admission Record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included Vascular Dementia (problems with reasoning, planning, judgement, memory, and other thought process) and Major Depressive Disorder (a serious mental disorder that affects how a person feels, thinks, and acts). An interview and record review on 10/23/24 at 9:27 A.M., with Licensed Nurse (LN) 1 was conducted. LN 1 stated Resident 47 was on Seroquel (medication used to treat mental disorders) 12.5 milligram (mg- metric unit of measurement) at bedtime. LN 1 stated there was no specific behavior monitoring for its use on the Physician's orders, the medication administration record (MAR), or the care plan. LN 1 stated that decline in mood changes, falls, and medication side effects were not specific and appropriate behaviors for monitoring psychotropic medications. 2. A review of Resident 105's Admission Record indicated Resident 105 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder. A review of Resident 105 's Physicians order indicated that Resident 105 was on the following psychotropic medications: Lorazepam (medication for mental disorders) 0.5 mg via Gastrostomy tube (GT-a feeding tube inserted through the stomach) every four hours as needed for anxiety. Citalopram (medication for mental disorders) 10 mg via GT daily - for depression. An interview and record review on 10/23/24 at 9:27 A.M., with Licensed Nurse (LN) 1 was conducted. LN 1 could not find specific behavior monitoring for the lorazepam and citalopram. LN 1 stated there was no specific behavior monitoring for its use on the Physician's orders, the MAR, or the care plan. An interview on 10/24/24 at 9:05 A.M., with the Director of Nursing (DON) was conducted. The DON stated the indication for the specific behavior was important to know if the medication was effective and to communicate to healthcare staff, the plan of care for Resident 47 and Resident 105. The DON acknowledged that the targeted behaviors for monitoring the psychotropic medications were too broad and vague for Resident 47, and that Resident 105 had no behavior monitoring. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy, titled Behavior /Psychoactive Drug Management indicated, dated November 2018, .Procedure .F. Any order of psychoactive medications must include .v. specific behavior manifested .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50175 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5 percent when three of 27 medications were not given as ordered by the physician. This failure had the potential for significant medication errors which could have caused residents to experience harmful side effects. Findings: 1. A medication administration observation was conducted on 10/23/24 at 8:01 A.M. for Resident 16. Licensed Nurse (LN) 22 administered famotidine (medication used to prevent heartburn) to Resident 16. A review of Resident 16's active physician's orders, dated October 2024, was conducted on 10/23/24. This record did not include a physician's order to administer famotidine to Resident 16. A concurrent observation and interview was conducted with LN 22 on 10/23/24 at 10:59 A.M. LN 22 reviewed the medication packets in Resident 16's section of the medication cart. It was found that famotidine was from Resident 60, who was assigned to the bed next to Resident 16. LN 22 acknowledged a medication error had occurred which could have negatively affected Resident 16 if he had been allergic to the medication. 2. A medication administration observation was conducted on 10/23/24 at 8:01 A.M. for Resident 16. LN 22 did not prepare and administer cholecalciferol (Vitamin D) as ordered. A review of Resident 16's active physician's orders, dated October 2024, was conducted on 10/23/24. This record included an order dated 10/13/21, for cholecalciferol capsule 5000 units by mouth one time per day for Vitamin D deficiency. An interview was conducted on 10/23/24 at 10:59 A.M. with LN 22. LN 22 stated she did not realize that she did not administer Vitamin D to Resident 16. 3. A medication administration observation was conducted on 10/23/24 at 8:44 A.M. for Resident 50. LN 22 prepared Levothyroxine (thyroid medication) to administer to Resident 50. The medications were administered through a gastrostomy tube (g-tube, a tube surgically inserted in the stomach to provide nutrition and medications). LN 22 turned off the tube feeding (nutrition given through a g-tube) and proceeded to administer the prepared medications to Resident 50. A review of Resident 50's physician's orders, dated 9/24/24, indicated Levothyroxine 88 micrograms (mcg) should be given once per day at 1 P.M. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview was conducted with LN 23 on 10/23/24 at 3:25 P.M. LN 23 stated the levothyroxine was in the morning medication section designated for the 9 A.M. medications. LN 23 stated the medications should have been organized to prevent medications from being misplaced. LN 23 stated medications like levothyroxine should have been given at the scheduled time because it could have affected the therapeutic level of the medication (the level of the medicine in the blood to work well in the body). A concurrent interview and record review was conducted with the Director of Nursing (DON) on 10/24/24 at 8:50 AM. The DON stated the order for levothyroxine was timed for (to be administered at) 1 P.M. The DON stated levothyroxine should have been given on an empty stomach. The DON stated the order for tube feeding was scheduled to start at 2 P.M. and stop at 10 A.M., and she could see why levothyroxine was scheduled for 1 P.M. The DON stated the consequence of not administering levothyroxine at the ordered time was that the medication would be less effective. A review of the facility's policy titled Medication - Errors, revised 7/2018, indicated, .II. Medication Error means the administration of medication: A. To the wrong resident; B. At the wrong time .E. Which is not currently prescribed .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50175 Based on observation and interview, the facility failed to ensure medication storage rooms were free from expired medical supplies when: 1. Expired needles and eyewash solutions were found in one of two medication storage rooms. 2. Expired needles were found in one of three medication carts. These failures had the potential to cause infection if the expired items were used on residents. Findings: 1. An observation of a medication storage room was conducted on [DATE] at 7:50 A.M. Needles used for injections, were observed in the medication storage room with expiration dates of [DATE], [DATE], and [DATE]. The expired needles were mixed with needles that were not expired. In addition, eyewash solution bottles were observed in the medication storage room with an expiration date of ,d+[DATE]. A concurrent observation and interview was conducted with Licensed Nurse (LN) 31. LN 31 stated the needles and eyewash solution were expired and should not have been in the medication storage room. LN 31 stated the expired items should have been discarded. 2. An observation of medication cart #5 was conducted with LN 25 on [DATE] at 1:07 P.M. LN 25 found expired needles in the cart with expiration dates of ,d+[DATE] and [DATE]. LN 25 stated using expired needles could have caused infection to the resident if used. Per the manufacturer's guidelines for the eyewash solution, titled Eyewash Saline, revised [DATE], .Active Ingredient: Sterile (free of germs) water . Per the manufacturer's guidelines for the needles, titled [Brand Name] Needle, revised February 2012, . Sterile .Non-pyrogenic (does not cause a fever) . An interview was conducted with the Director of Nursing (DON) on [DATE] at 1:11 P.M. The DON stated medical supplies would not have been sterile if it was expired. The DON stated if the expired medical supplies were used, there could have been bacteria in the expired items. The DON stated there should not have been expired items in the medication storage rooms or the medication carts. The facility's policy, titled Medication Storage in the Facility, dated [DATE], did not direct the facility to discard expired medical supplies.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 39448 Based on observation and interview, the facility failed to ensure one of one sampled kitchen staff (Cook 12) properly tested the kitchen disinfectants. As a result, the disinfectant may not have been at the proper strength to disinfect surfaces. Findings: On 10/22/24 at 8:30 A.M., an observation was conducted in the kitchen. [NAME] 12 tested the disinfectant in a red bucket used for sanitizing surfaces in the kitchen. [NAME] 12 dipped a test strip into the disinfectant then immediately pulled it out to check the color. [NAME] 12 stated, he only needed to dip the strip in the disinfectant for one second. The test strip container's directions read, .Immerse for 10 seconds, compare when wet . After being asked why he did not follow the directions on the test strip container, [NAME] 12 retested the disinfectant by immersing a test strip for seven seconds. On 10/22/24 at 8:35 A.M., an interview was conducted with the Registered Dietician (RD). The RD stated, when the kitchen staff were testing the disinfectant in the red buckets, they should have held the test strip in the liquid for 10 seconds. The facility did not have a policy on testing the red bucket disinfectant.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39448 Based on observation and interview, the facility failed to ensure frozen meat was thawed appropriately during one of two sampled observations of thawing meat. As a result, there was an increased risk of food-borne illness. Findings: On 10/22/24 at 11:55 A.M., an observation and interview was conducted with the Dietary Manager (DM). A plastic bag containing cubes of meat was observed floating in a container of water on a counter in the kitchen. The DM stated, it was frozen chicken thawing in sitting water. The DM further stated, it should have been thawing in the refrigerator, or under running water. The DM stated that the cook who placed the frozen chicken in standing water knew that was not the proper way to thaw frozen meats. Per the facility's policy, titled Food Storage and Handling, revised 2/29/24, .Thaw foods .in the refrigerator .

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to ensure arbitration agreements (a legal contract) were signed by the Responsible Party (RP) for two of three residents sampled for arbitration agreements (67, 171). As a result, Resident 67 and Resident 171 entered into a legal agreement when they did not have the ability to understand what they were signing. Findings: 1. Resident 67 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental disorder involving a disconnection from reality). Per the facility's History and Physical Examination (a physician's assessment), dated 1/16/24, Resident 67 did not have the capacity to understand and make decisions. A review of Resident 67's medical record was conducted. Resident 67 signed the Arbitration Agreement on 1/16/24. The staff member responsible for completing Arbitration Agreements was not available for interview. 2. Resident 171 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental disorder involving a disconnection from reality). Per the facility's History and Physical Examination, dated 10/6/23, Resident 171 could not make medical decisions. A review of Resident 171's medical record was conducted. Resident 171 signed the Arbitration Agreement on 10/7/23. The staff member responsible for completing Arbitration Agreements was not available for interview. On 10/24/24 at 10:22 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, if a resident did not have the capacity to make their own decisions, then the Arbitration Agreement should have been signed by the resident's responsible party instead of the resident. Per the facility's policy titled P-AD 17 Arbitration Agreements, revised 5/25/23, .If the resident has capacity at the time of admission, the resident may sign the arbitration agreement .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39449 Based on observation, interview and record review, the facility failed to follow infection control practices when the facility: 1.) Did not consistently check water temperature or test the water for germs. 2.) A personal belonging was on top of a clean bed that was intended for a new resident admission. 3.) Licensed Nurses (LNs) did not perform hand hygiene after administering medications between residents (16, 60). These failures had the potential to spread germs and placed residents at risk for infections. Findings: 1. Per the facility policy titled Water Management, revision date 5/25/23, .The facility will develop and utilize water management strategies .to reduce the risk of growth and spread of Legionella (a type of germs in water) and other opportunistic water-borne pathogens in facility water systems . Control Measures and Corrective Actions .1 .the team will identify needed control measures .and how to monitor them .2. Physical and chemical measures . that may be applied for the prevention and control of Legionella include, but are not limited to: a. Maintaining Water heaters at appropriate temperatures of 140 F (60 C) at the hot water heater outlet; and hot water temperatures at coldest point at 124 F (51 C) .b. Quarterly measurement of water quality throughout the system to ensure changes that may lead to Legionella growth are not occurring . There was no documented evidence provided by the facility to indicate water temperature was checked before October 24, 2024. There was no documented evidence provided by the facility to indicate the water was being tested (for water-borne pathogens). On 10/24/24 at 9:38 A.M., an interview with the Maintenance Director (MD) and the Infection Preventionist (IP) was conducted. The MD stated that they did not do biological (monitoring of pathogens and microorganisms in the water supply) testing. The IP stated our [company] plan was not to test water unless there was a cluster (group with infections) like pneumonia (respiratory infection) and diarrhea was present in the facility. On 10/24/24 at 1:49 P.M., an interview and record review were conducted with the director of nursing (DON) and the MD. The MD stated he could not find any logs for water temperature. The facility was not able to provide water temperature logs for 2024 before 10/24/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 10/22/24 at 11:51 A.M., an observation and interview were conducted with LN 31. A comb was observed on top of a clean bed with a sign posted that read, 'Clean and Disinfected Ready for Admission. LN 31 stated the comb should not have been there and the bed should have been cleaned for the next resident. LN 31 stated they would call housekeeping to change the bed (linens) and we don't know if the comb was used. On 10/24/24 at 8:40 A.M., an interview with LN 31 and LN 32 was conducted. LN 31 stated she could not tell whether the comb on top of the bed was clean or not. LN 31 stated that they had to clean, disinfect, and prepare the bed for a new resident. LN 32 stated they should have made the bed again because there was no way for sure to know if the comb was used or not. LN 32 stated the facility did not want any resident to become infected with germs. LN 32 stated there should not have been anything on a clean bed. On 10/24/2024 at 12:40 P.M., an interview was conducted with the director of nursing (DON). The DON stated the comb should have been put in lost and found and housekeeping should have redone (placed new linens on) the bed. The DON stated that a new resident should be placed in a clean environment without bed bugs or lice. The DON stated she was not sure the if the comb was used or not. 50175 3. Medication administration observations were conducted on 10/23/24 starting at 8:01 A.M., with LN 22 for Resident 16. LN 22 did not perform hand hygiene after administering medications to Resident 16. LN 22 proceeded to prepare medications for Resident 60. LN 22 did not perform hand hygiene before entering Resident 60's room to administer Resident 60's medication. LN 22 stated she did not perform hand hygiene between giving medication to different residents. LN 22 stated the importance of hand hygiene was to stop the spread of infection. An interview was conducted with the infection preventionist (IP) on 10/24/24 at 12:39 P.M. The IP stated that hand hygiene was the number one way to prevent infection. The IP stated the expectation was for staff to perform hand hygiene in between care for residents, and when going in and out of a room. An interview was conducted with the director of nursing (DON) on 10/24/24 at 12:54 P.M. The DON stated the expectation was for staff to perform hand hygiene in between residents. A review of the facility's policy titled Hand Hygiene, revised 9/1/20, indicated .The Facility considers hand hygiene as the primary means to prevent the spread of infections .F. The following situations require appropriate hand hygiene: .vii. Immediately upon entering and exiting a resident room .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39448 Based on observation, interview, and record review, the facility failed to ensure the food preparation area was free of insects for one of one sampled kitchens. As a result, there was an increased risk of food-borne illness. Findings: On 10/22/24 at 11:05 A.M., an observation was conducted in the kitchen. [NAME] 13 was chopping roast pork, while a winged black insect (Insect 1) was flying around the pork. [NAME] 13 repeatedly waved her hand at Insect 1 while she was chopping the roast pork. Insect 1 landed on a piece of chopped pork and then flew away. [NAME] 13 did not remove the contaminated piece of food and continued chopping the roast pork. On 10/22/24 at 11:15 A.M., an interview was conducted with the Registered Dietician (RD). The RD stated, the facility was planning on getting an air curtain (a device to stop flying insects from entering) installed on the exterior kitchen door. The RD further stated, the Maintenance Director (MD) knew more about the plans for installing the air curtain. On 10/22/24 at 11:30 A.M., an observation was conducted of the kitchen. A winged small insect (Insect 2) was observed on the wall above the ice machine. On 10/22/24 at 11:35 A.M., an observation was conducted of the kitchen. A winged black insect (Insect 3) was observed flying above the food that kitchen staff were preparing to serve for lunch. On 10/22/24 at 11:50 A.M., an observation was conducted of the kitchen. A winged orange and black striped insect (Insect 4) was observed flying around the kitchen while kitchen staff were preparing food for lunch. On 10/23/24 at 12:52 P.M., an interview was conducted with the MD. The MD stated, he was not aware of any pest concerns in the kitchen, and was not aware of any plans to install an air curtain on the exterior kitchen door. A review was conducted of the facility's policy, titled Pest Control, revised 1/1/12. The policy did not mention management of pests in the kitchen.