STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055430	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Hills Health Care Ctr	10426 Bogardus Ave Whittier, CA 90603

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to promote dignity and respect for two of two sampled residents (Resident 18 and Resident 100) by: 1. Leaving the privacy curtain opened while Resident 100 was being assisted with dressing change. 2. Leaving indwelling catheter drainage bag (a flexible tube used to empty the bladder and collect urine in a drainage bag) uncovered for Resident 18 who required the use of an indwelling catheter. As result of the failure, Resident 100 verbalized being hurt and potentially resulted in emotional distress. These deficient practices had the potential to cause a decline in Resident 18's dignity, self respect, self-esteem, and self-worth. Findings: 1. During a review of Resident 100's Admission Record, indicated Resident 100 was admitted to the facility on [DATE] with diagnosis that included pneumonia (severe lung infection [the invasion and growth of germs in the body]), sepsis (the body's extreme response to an infection), acute respiratory failure (condition in which not enough oxygen passes from the lungs into the blood), difficulty in walking, and muscle weakness. During a review of Resident 100's Minimum Data Sets (MDS - a federally mandated resident assessment tool), dated 11/23/2024, indicated Resident 100 ' s cognition (ability to think, remember, and reason with no difficulty) was severely impaired, and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in lower body dressing (the ability to dress and undress below the waist, including fasteners). During a review of Resident 100's Care plan for activities of daily living focused on self-care performance deficit, dated 11/30/2024, included interventions that indicated the resident will be provided with privacy to promote dignity. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/7/2025 at 10:30 AM in Resident 100's room, Rehabilitation Aide (RA) 1 and Physical Therapist Assistant (PTA) 1 were assisting Resident 100 to dress up and pull his pant. Resident 100's privacy curtain was opened and exposed from the waist down. Resident 100 started yelling and requested RA 1 to close his privacy curtain. RA 1 apologized to Resident 100, stated I'm sorry, I'll pull the curtain right now, it's dignity, then pulled the privacy curtain and continue to assist Resident 100 with dressing. During an interview on 1/7/2025 at 10:50 AM with RA 1, RA 1 stated, he was helping PTA 1 to change Resident 100 into his personal clothes from the hospital gown to prepare him for his physical therapy session. RA 1 stated, he and PTA 1 should have provided privacy for the resident. RA 1 stated, the curtain should have been pulled prior to assisting with dressing. During an interview on 1/7/2025 at 11:30 AM with Resident 100, Resident 100 stated, he felt hurt being exposed from his waist down and stated, it was not acceptable. During an interview on 1/9/2025 at 4:28 PM with the Director of Nurses (DON), the DON stated, she expected her staffs to close the curtain to provide privacy any time they do care. The DON stated, it was important to provide privacy because no resident would want any stranger to see their body. The DON stated, Resident 100 could have been upset, and got stressed out about the incident. During a review of the facility's policy and procedure (P&P) titled, Resident Rights - Dignity and Privacy, dated 11/2021, indicated it is the policy of the facility that all residents be treated with kindness, dignity, and respect. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. 42854 2. During a review of Resident 18's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood), metabolic encephalopathy (disorder that affects brain function that can cause confusion, memory loss, and loss of consciousness), and abnormalities of gait and mobility. During a review of Resident 18's Minimum Data Set (MDS, a resident assessment tool) dated 10/28/2025, indicated resident ' s cognition (mental action or process of acquiring knowledge and understanding through thought, experience and the senses) was intact. During a review of Resident 18's Orders dated 12/23/2024 indicated a physician order for indwelling catheter #16/10 milliliters (size of indwelling catheter- 16 inch long 10 milliliter wide) to close drainage system (A closed urinary drainage system consists of a catheter inserted into the urinary bladder and connected via tubing to a drainage bag.) for obstructive uropathy (a condition in which the flow of urine is blocked). During an observation in Resident 18's room on 1/6/2025 at 9:56 AM, Resident 18 was observed sleeping in bed. Observed Resident 18 ' s foley catheter drainage bag hanging on resident's bed frame without a dignity cover bag. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in Resident 18's room om 1/6/2025 at 10:19 AM, the Assistant Director of Nursing (ADON) verified there was no dignity bag to cover resident's foley drainage bag. The ADON stated residents only need a dignity bag when they are out of their room. During an interview with the Director of Nursing (DON) on 1/10/2025 at 11:02 AM, the DON stated resident's foley drainage bag should be covered with a dignity cover at all times for privacy. During a review of the facility's policy and procedure (P&P) titled Dignity and Privacy, dated 11/2021 indicated all residents will be treated with kindness, dignity, and respect. The P&P indicated privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the Resident's safety.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of need for four out of four sampled residents (Resident 3, 72, 81 and 93) by failing to: 1. Ensure Resident 72 had a functional televevision for personal use as identified in the resident's care plan. 2. Ensure the resident's call light was within reach as indicated in the facility's policy and procedure and resident's care plan for Resident 3, 81, and 93. These deficient practices resulted in Resident 72 not having a television to use that negatively impacted the resident's quality of life and emotional well-being. These deficient practices also had a potential for Resident 3, 81 and 93 not to receive or received delayed care to meet necessary care, ensure their safety and potentially lead to fall and accident with injury. Findings: 1. During a review of Resident 72's Admission Record, the facility admitted Resident 72 on 10/05/2024, with diagnoses including Asthma (lung disease that makes breathing difficult), and history of falling. During a review of Resident 72's History and Physical (H&P), dated 10/8/2024 indicated, Resident 72 had the mental capacity to make medical decisions. During a review of Resident 72's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/12/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and needed supervision to extensive assistance from the staff for the activities of daily living. During a review of Resident 72's activity plan of care initiated on 10/7/2024 indicated Resident 72 enjoys watching T.V. (Television) provided by the facility with a goal date of 4/5/2025. During a review of Resident 72's Activity- Admission Evaluation indicated that Resident 72 enjoyed watching Television as one of her activity interests. During a concurrent observation and interview on 1/6/2025 at 9:35 AM with, with Resident 72 in Resident 72's room was observed seated in her bed. Resident 72 stated she was unable to use her own television because it was not functioning and had been sharing the television located on Resident 136 ' s side of the room. During observation, the privacy curtain was drawn while staff provided care to Resident 136, making the television unavailable to Resident 72. Resident 72 appeared visibly agitated, stating, I can't even watch TV when they're taking care of her open the curtain, please. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/6/2025 at 9:35 AM with the Resident 72 in Resident 72's room stated, My TV hasn ' t worked for since I was admitted so I must watch the other TV. But when they close the curtain to take care of her, I can't even see or hear it. It's really frustrating because I love watching TV, it's what I look forward to most during the day. During an interview on 1/6/2025 at 10:30 AM, the Case Manager (CM 1) stated that Resident 72 enjoys watching television for entertainment and emotional well-being, as it provides a sense of normalcy and distraction. The case manager stated, Not having access to her own television has caused her to feel frustrated and excluded, especially when she's unable to watch the shared television due to the privacy curtain being drawn. This has made her more agitated and impacts her overall mood. During a concurrent observation and interview on 1/6/2025 at 10:35 AM, with Resident 136's Family member (FM1), in Resident 136's room, Resident 136 was observed lying on her bed and stated, FM 1 stated, I'm fine with her watching Resident 136's television. Luckily, they like the same programs, but it would be a problem if they didn't. It does limit both of them to watching the same thing. During an interview on 1/8/2025 at 10:15 AM, the facility's maintenance staff member (FMS 1) stated they were aware of the issue with Resident 72's television and stated, We are aware that her TV isn't working and have been meaning to fix it. I'll get to it as soon as possible. During an interview on 1/9/2025 at 4:45 PM, the facility administrator recognized the issue and stated, we want residents to have access to their amenities, but we didn't fix this quickly enough. I'll make sure maintenance fixes it and work with staff to respond faster in the future. 42878 2a. During a review of Resident 3's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 3 was readmission to the facility on [DATE] with diagnoses that included of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance), chronic obstructive pulmonary disease (a diseases that blocks airflow and make it hard to breathe) and risk for fall. During a review of Resident 3's History and Physical (H&P), dated 12/24/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 3's care plan for falls, initiated on 12/24/2024, indicated Resident 3 was at risk for falls. The care plan interventions included be sure the call light is within reach and encourage to use it to call for assistance as needed. The care plan also indicated to keep the resident needed items within reach, such as water,etc. During an observation in Resident 3's room on 1/6/2025 at 10:17 AM, Resident 3 was observed sleeping in his bed. Resident 3's call light was observed hanging between the headboard and wall, not within Resident 3's reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in Resident 3's room on 1/6/2025 at 10:18 AM, Certified Nursing Assistant (CNA) 2 stated Resident 3's call light should not be hanging between the headboard and wall. CNA 2 stated he did not know who put it there but Resident 3 was not able to reach or pull out the call light from where it was, CNA 2 stated it was important for Resident 3's call light to be within reach so the resident can call for help. 2b. During a review of Resident 81's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included hypotension (low blood pressure), unsteadiness of feet, and history of falls. During a review of Resident 81's History and Physical (H&P), dated 10/13/2024, indicated the resident could make needs known but could not make medical decisions. During a review of Resident 81's Minimum Data Set (MDS - a resident assessment tool), dated 11/5/2024, indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 81's care plan for falls, initiated on 10/12/2024, indicated Resident 81 was at risk for falls. The care plan included interventions for staff to be sure the call light is within reach and encourage to use it to call for assistance as needed. The care plan also indicated the resident needs a safe environment that included a working and reachable call light. During a review of Resident 81's Fall Risk Evaluation dated 11/11/2024 indicated resident was at high risk for falls. During an observation in Resident 81's room on 1/6/2025 at 9:27 AM, Resident 81 was observed sleeping in his bed. Resident 81's call light was observed on the floor and not within his reach. During a concurrent observation and interview in Resident 81's room on 1/6/2025 at 9:44 AM, Certified Nursing Assistant (CNA) 2 stated it was important for Resident 81's call light within his reach so the resident can call for help or call when they need something. 2c. During a review of Resident 93's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included metabolic encephalopathy (disorder that affects brain function that can cause confusion, memory loss, and loss of consciousness), cognitive communication deficit, and difficult walking. During a review of Resident 93's History and Physical (H&P), dated 9/12/2024, indicated the resident had the capacity to understand and make decisions. During a review of Resident 93's MDS, dated [DATE], indicated the resident had moderately impaired cognitive skills for decision making. During a review of Resident 93's care plan for falls, initiated on 9/15/2024, indicated Resident 93 was at risk for falls. The care plan included interventions for staff to be sure the call light is within reach and encourage to use it to call for assistance as needed. The care plan also indicated the resident needs a safe environment that included a working and reachable call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 93's Fall Risk Evaluation dated 9/14/2024 indicated resident was at high risk for falls. During an observation in Resident 93's room on 1/6/2025 at 9:39 AM, Resident 93 was observed sleeping in his bed. Resident 93's call light was observed on the headboard of his bed and not within his reach. During a concurrent observation and interview in Resident 93's room on 1/6/2025 at 9:45 AM, CNA 2 stated resident's call light should be next to resident withing his reach and not on the headboard. During an interview with the Director of Nursing (DON) on 1/10/2025 at 11:04 AM, the DON stated residents' call light should be within reach of the residents so they can call for assistance when needed and get help. During a review of the facility's policy and procedure (P&P) titled Safety, Resident, dated 9/2019, the P&P indicated to place call light within reach of the resident.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 47467 Based on observation, interview, and record review, the facility failed to ensure six of twelve sampled residents who attended the Resident Council meeting on 1/7/2025 was aware of the Ombudsman's (a state agent that advocates for the residents) contact number. This deficient practice had the potential to violate the residents' rights to seek assistance from the Ombudsman or resident advocacy groups should unresolved issues arise from the facility. Findings: During a group interview on 1/7/2025 at 3:35 PM with twelve facility residents during the facility's Resident Council meeting, six residents indicated they were not aware of who and how to contact the Ombudsman's office. All six residents indicated it would be helpful to be aware of the role and how to contact the Ombudsman for questions or unresolved issues in the facility. During an interview on 1/9/2025 at 12:10 PM with the Activity Director (AD), the AD stated, Resident Council meeting was held monthly, and she did not have any documented evidence that she explained to the residents about the Ombudsman's role and provided the residents with the Ombudsman's contact phone number. During an interview on 1/9/2025 at 12:30 PM with the Admission Assistant (AMA) 1, AMA 1 stated, there was no documented evidence that the facility explained to the residents about the Ombudsman's role and provided them with the Ombudsman's contact phone number upon admission. During an interview on 1/9/2025 at 4:30 PM with the Director of Nurses (DON), the DON stated, it was important for the residents to know the Ombudsman's contact phone number because it was one of the Resident Rights. The DON stated, if the residents were aware of the Ombudsman's contact phone number, the residents could make sure their voice was heard and had choices if they did not feel comfortable talking to the facility. During a review of the facility's policy and procedure titled, Resident Rights, undated, indicated the facility's residents have the right to have access to the names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 47467 Based on observation, interview, and record review, the facility failed to ensure six (6) of twelve (12) sampled residents who attended the Resident Council meeting on 1/7/2025 was aware of where to find and able to read the facility's previous Annual Recertification Survey with Plan of Correction POC) results. This deficient practice had the potential for the residents and their legal representatives to not be fully informed of the facility's deficient practices and how the facility corrected the deficient practices. Findings: During a group interview on 1/7/2025 at 3:35 PM with twelve facility's residents when the facility's Resident Council meeting was held, six residents stated they were not aware of where to find the facility's Annual Recertification Survey with Plan of Correction (POC) from the previous survey results. All six residents indicated it would be helpful to be aware of where to find the facility's previous survey results and able to know the deficiencies were corrected. During an interview on 1/9/2025 at 12:10 PM with the Activity Director (AD), the AD stated, Resident Council meeting was held monthly, and she did not have documented evidence that she informed or reminded the residents where to find the facility's previous Survey results. During an interview on 1/9/2025 at 12:30 PM with the Admission Assistant (AMA) 1, AMA 1 stated, there was no documented evidence that they included the information for where to find the facility's previous survey results when explaining Resident rights to the residents upon admission. During an interview on 1/9/2025 at 4:30 PM with the Director of Nurses (DON), the DON stated, it was important for the residents to know where the facility's previous survey results binder was and examine the results because it was one of the resident rights. During a review of the facility's policy and procedure titled, Resident Rights, undated, indicated the facility's residents have the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.

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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** 42878 Based on interview and record review for one of three sampled residents (Resident 3), the facility failed to ensure Resident 3's Advance Directive (living will, legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) was in Resident 3's chart. These deficient practices had the potential to result in misinformation of medical care and treatment and not honoring resident's wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: During a review of Resident 3's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance), chronic obstructive pulmonary disease (a diseases that blocks airflow and make it hard to breathe. During a review of Resident 3's History and Physical (H&P) dated 12/24/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 3's Physician Orders for Life Sustaining Treatment (POLST) dated 10/28/2024, the POLST indicated the resident had an Advance Directive dated 3/13/2022. During an interview and concurrent record review on 1/08/2025 at 9:08 AM of Resident 3's chart with Social Service Assistant (SSA), SSA stated Resident 3's POLST indicated Resident 3 had an Advance Directive but could not locate the Advance Directive in Resident 3's chart. SSA stated it might have been placed somewhere else in between Resident 3's last transfer to the Hospital and readmission to the facility. During an interview on 1/10/2025 at 2:25 PM with Director of Nursing (DON), DON stated if a Resident has an advance directive the copy should be kept in the Resident's chart. The DON stated it is important for the facility to keep a paper copy in the chart in case of any emergency, all staff and emergency medical services have access to the Resident's Advance Directive. During a review of the facility's policy and procedure (P&P) titled Advanced Directives and Associated Documentation dated revised on 12/2023 indicated It is the policy of this facility to inform and provide written information to all adult residents concerning the right to obtain a copy of the Advanced Directive and conservatorship/guardianship documents and place in residents health record.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to ensure the comprehensive Minimum Data Sets (MDS - a federally mandated resident assessment tool) were completed and submitted in the CMS (Centers for Medicare and Medicaid Services- Long Term Care) data base within the required time frame for one (1) out of four sampled residents (Resident 22). This deficient practice had the potential for Resident 22 to not receive care and services that could negatively affect the provision of necessary care and services . Findings: During a review of Resident 22's Admission Record, indicated Resident 22 was admitted to the facility on [DATE] with diagnosis that included hemiplegia (a condition that causes weakness or loss of the ability to move on one side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, abnormal posture (the way a person hold the body, whether sitting, standing, or lying down), muscle weakness (generalized), and dysphagia (difficulty swallowing). During a review of Resident 22's annual comprehensive MDS indicated 12/1/2024 as the assessment reference date (ARD- last day of the observation period that the assessment covers for the resident). During a concurrent interview and record review on 1/8/2025 at 3:36 PM with the MDS Nurse (MDSN), the MDSN stated, she had 14 days to complete the assessment after the ARD. The MDSN stated, Resident 22's annual comprehensive MDS should have been completed and submitted to the CMS data base on 12/15/2024. The MDSN stated she had not yet completed/submitted the assessment. During an interview on 1/8/2025 at 4:04 PM with the MDSN, the MDSN stated, she had been late with residents MDS assessment and submission to the CMS data system and was trying to catch up. During an interview on 1/9/2025 at 4:28 PM with the Director of Nursing (DON), the DON stated the MDSN was in charge for updating and transmitting the MDS quarterly and annually, and the MDS assessment should be done on time. The DON stated it was important to complete and transmit MDS timely to make sure the resident ' s status was accurate and most updated so the care plan could be revised or initiated based on the resident's conditions timely. During a review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual, Version 1.17.1, dated October 2019, indicated for the annually comprehensive MDS assessment, the MDS completion date must be no later than 14 calendar days following the ARD. (continued on next page)

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Whittier Hills Health Care Ctr	10426 Bogardus Ave Whittier, CA 90603

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Job Description-Minimum Data Set (MDS Coordinator-RN), dated 12/17/2021, indicated the position ' s responsibility is to conduct and coordinate the development and completion of the Resident Assessment Instrument (RAI), that is, the Minimum Data Set (MDS), Care Area Assessments (CAAs) and Care Plan in accordance with State and Federal requirements. During a review of the facility's P&P titled, Resident Assessment Instrument (RAI), dated 10/1/2023, indicated the Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual Version 1.17.1 October 2019 will be the source guidance for the RAI Process.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview and record review, the facility failed to ensure the quarterly Minimum Data Sets (MDS - a federally mandated resident assessment tool) were completed and submitted in the CMS (Centers for Medicare and Medicaid Services- Long-Term Care) data base within the required time frame for three (3) out of four sampled residents (Residents 85, 98, and 116). This deficient practice had the potential for Residents 85, 98, and 116 to not receive care and services that could negatively affect the provision of necessary care and services. Findings: a. During a review of Resident 85's Admission Record, indicated the facility initially admitted Resident 2 on 2/21/2022 and readmitted on [DATE] with diagnosis that included difficulty walking, muscle weakness (generalized), and type 2 diabetes mellitus ((DM2 - condition that results in too much sugar circulating in the blood). During a review of Resident 85's quarterly comprehensive MDS, indicated 11/18/2024 as the assessment reference date (ARD- last day of the observation period that the assessment covers for the resident), and the date Registered Nurse Assessment Coordinator (RNAC) signed assessment as complete was on 1/8/2025. During a concurrent record review and interview on 1/8/2025 at 3:38 PM with the MDSN, Resident 85's quarterly MDS was reviewed. The MDSN stated, Resident 85's quarterly MDS should have been completed and submitted to the CMS data base on 12/2/2024. The MDSN stated, she completed the MDS assessment on 1/8/2025, which was 37 calendar days late. b. During a review of Resident 98's Admission Record, indicated the facility admitted Resident 98 on 8/31/2022 and readmitted on [DATE] with diagnosis that included severe sepsis [the body's extreme response to an infection (the invasion and growth of germs in the body)], seizures (a sudden burst of electrical activity in the brain), and muscle weakness. During a review of Resident 98's quarterly comprehensive MDS, indicated 11/21/2024 as the ARD, and the date RNAC signed assessment as complete was left blank. During a concurrent record review and interview on 1/8/2025 at 3:42 PM with the MDSN, Resident 98's quarterly MDS was reviewed. The MDSN stated, Resident 98's quarterly MDS should have been completed and submitted to the CMS data base on 12/5/2024, The MDSN stated, she had not completed and submitted the MDS assessment yet. c. During a review of Resident 116's Admission Record, indicated the facility admitted Resident 116 on 10/1/2023 with diagnosis included hyperlipidemia (an excess of fats in the blood), dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], and anxiety (a group of mental disorders characterized by significant feelings of fear that affect with daily activities). (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 116's quarterly comprehensive MDS, indicated 11/29/2024 as the ARD, and the date RNAC signed assessment as complete was left blank. During a concurrent interview and record review on 1/8/2025 at 3:36 PM with the MDS Nurse (MDSN), the MDSN stated, she had 14 days to complete the assessment after the ARD. During a concurrent record review and interview on 1/8/2025 at 3:46 PM with the MDSN, Resident 116's quarterly MDS was reviewed. The MDSN stated, Resident 116 ' s quarterly MDS should have been completed and submitted to the CMS data base on 12/13/2024, The MDSN stated, she had not completed and submitted the MDS assessment yet. During an interview on 1/8/2025 at 4:04 PM with the MDSN, the MDSN stated, she had been late with MDS assessment and submission and was trying to catch up. During an interview on 1/9/2025 at 4:28 PM with the Director of Nursing (DON), the DON stated the MDSN was in charge for updating and transmitting the MDS quarterly and annually, and the MDS assessment should be done on time. The DON stated it was important to complete and transmit MDS timely to make sure the resident ' s status was accurate and most up to date so that the care plan could be revised or initiated based on the resident's conditions timely. During a review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, dated October 2019, indicated for the quarterly non-comprehensive MDS assessment, the MDS completion date must be no later than 14 calendar days following the ARD. During a review of the facility's policy and procedure (P&P) titled, Job Description-Minimum Data Set (MDS Coordinator-RN), dated 12/17/2021, indicated the position's responsibility is to conduct and coordinate the development and completion of the Resident Assessment Instrument (RAI), that is, the Minimum Data Set (MDS), Care Area Assessments (CAAs) and Care Plan in accordance with State and Federal requirements. During a review of the facility's P&P titled, Resident Assessment Instrument (RAI), dated 10/1/2023, indicated the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1 October 2019 will be the source guidance for the RAI Process.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42854 Based on interview and record review, the facility failed to develop a personal centered individualized care plan (a healthcare plan specifically tailored to an individual's unique needs, preferences, and values) that included interventions to prevent elopement (an incident where a resident leaves the facility unsupervised and without staff knowledge) for four out of four sampled residents (Residents 29, 56, 89, and 154), who were at risk for elopement. This deficient practice put Resident 29, 56, 89, and 154 to not receive appropriate care, supervision, treatments, and/or services from staff, compromises the safety and potentially put these residents at risk of elopement and the danger that associated with elopement. Findings: a. During a review of Resident 56's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone, can disrupt heart rate, body temperature and all aspects of metabolism), and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities). During a review of Resident 56's History and Physical (H&P), dated 9/27/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 56's Minimum Data Set (MDS - a resident assessment tool), dated 9/30/2024, indicated the resident had moderately impaired cognitive (thought process) skills for decision making. During a review of Resident 56's Elopement/Wandering Evaluation, dated 10/2/2024, indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 56's care plans on 1/10/2025 at 9:56 AM, MDS Nurse (MDSN) stated Resident 56's care plan for elopement was created on 1/7/2025. MDSN stated she could not find documented evidence of a care plan or interventions created after Resident 56 was evaluated for elopement/wandering on 10/2/2024. MDSN stated the purpose of the care plan is to take care of the resident and it was the staff's guide to improve or address any issues that the resident has. MDSN stated she added the care plan for elopement because resident was at high risk for elopement. MDSN stated she was unsure why the care plan was not created after 10/2/2024. MDSN stated if a care plan was not created, no interventions were in placed. During an interview with the Medical Records Director (MRD) on 1/10/2025 at 12:20 PM, MRD stated she could not find elopement/wandering risk documented in Resident 56's Interdisciplinary Team's (IDT) record for care planning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 154's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included disorders of urinary system, interstitial pulmonary diseases (group of disorders that cause progressive scarring of lung tissue), and Alzheimer's disease. During a review of Resident 154's MDS, dated [DATE], indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 154's Elopement/Wandering Evaluation, dated 12/25/2024, indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 154's care plans on 1/10/2025 at 10:29 AM, the Social Services Assistant (SSA) stated she met with Resident 154 on 1/7/2025. SSA stated Resident 154 seemed like a flight risk which was someone that can possibly leave the facility. SSA stated she did not review Resident 154's elopement risk assessment. SSA stated she created the care plan for elopement on 1/7/2025 because Resident 154 verbalized during the conversation she wanted to go home. SSA stated she could not recall if she documented the conversation. c. During a review of Resident 89's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included anemia (condition in which the blood doesn ' t have enough healthy red blood cells and hemoglobin [a protein found in blood cells] to carry oxygen all through the body), difficulty walking, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 89's History and Physical (H&P), dated 9/14/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 89's MDS, dated [DATE], indicated the resident ' s cognition as intact. During a review of Resident 89's Elopement/Wandering Evaluation, dated 9/4/2024, indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 89 ' s care plans on 1/10/2025 at 10:40 AM, the Assistant Director of Nursing (ADON) stated she was reviewing Resident 89's chart and a care plan for elopement on 1/7/2025. The ADON stated she could not find care plan or interventions created and documented after Resident 89 evaluated at high risk of elopement/wandering on 9/4/2024. During an interview with the Medical Records Director (MRD) on 1/10/2025 at 12:20 PM, MRD stated she could not find elopement/wandering risk documented in Resident 89's Interdisciplinary Team's (IDT) record for care planning. d. During a review of Resident 29's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included senile degeneration of brain, encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), and muscle weakness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's History and Physical (H&P), dated 10/18/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 29's MDS, dated [DATE], indicated the resident had severely impaired cognition. During a review of Resident 29's Elopement/Wandering Evaluation dated 11/16/2024 indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 29's care plans on 1/10/2025 at 10:41 AM, the Assistant Director of Nursing (ADON) stated Resident 29's care plan for elopement was created on 1/8/2025. The ADON stated she could not find a care plan or interventions created and documented after Resident 29 was evaluated for elopement/wandering on 11/16/2024. The ADON stated Resident 29 should have an active elopement care plan because she was at high risk for elopement. The ADON stated the care plan should include interventions to prevent elopement. During an interview with the Director of Nursing (DON) on 1/10/2025 at 10:54 AM, the DON stated it was important to develop a care plan for residents at risk for elopement so there are interventions to prevent elopement from happening. The DON stated the care plan should have been created as soon as facility knew resident was at risk. The DON stated if there was no care plan there was a possibility the resident could elope. The DON stated she expects the staff to review the elopement assessment and to create a care plan. The DON stated if there were any instances of eloping it should be documented in the progress notes. During an interview with the Medical Records Director (MRD) on 1/10/2025 at 12:20 PM, MRD stated she could not find elopement/wandering risk documented in Resident 29's Interdisciplinary Team's (IDT) record for care planning. During a review of the facility's policy and procedure (P&P) titled Comprehensive Resident Centered Care Plan revised on 12/2023 indicated the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident ' s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated the IDT will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. The P&P indicated the resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. During a review of the facility's policy and procedure (P&P) titled Elopement/Unsafe Wandering revised on 12/2023 indicated residents with high risk factors will be identified as At Risk and will have an individualized care plan developed that includes measurable objectives and time frames. The P&P indicated care plan interventions will consider the elements of the evaluation or behavior observations that identified the resident at risk. The P&P also indicated interventions will address the individualized level of supervision needed to prevent elopement/unsafe wandering.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Cross reference to F711, F867 Based on interview, and record review, the facility failed to provide care and services to one of - sampled residents (Resident 301) with diagnosis of Diabetes Mellitus (DM, condition that results in too much sugar circulating in the blood) by failing to: 1. Ensure Resident 301 ' s blood sugar was monitored for high or low blood sugar level. 2. Ensure Admitting Registered Nurse (RN) clarified with Resident 301 ' s physician for blood sugar monitoring and treatment. 3. Ensure Nurse Practitioner (NP) 1 thoroughly reviewed Resident 301 ' s General Acute Hospital (GACH) 1 ' s discharge packet when NP 1 took over the care of Resident 301 to clarify Resident 301 ' s history of type 2 Diabetes Mellitus as documented in Resident 301 ' s GACH 1 ' s H&P and justified the need to continue or discontinue blood sugar monitoring and treatment. These deficient practices had a potential to result in Resident 301 ' s to developed uncontrolled blood sugar level that could lead to complication such as ketoacidosis (metabolic condition that occurs when the body produces too many ketone bodies, which can lead to dangerous levels of acid in the blood) coma, hospitalization or death. Findings: During a review of Resident 301 ' s Admission Record, indicated Resident 301 was admitted to the facility on [DATE] with diagnosis that included hemiplegia (a condition that causes weakness or loss of the ability to move on one side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, hyperparathyroidism, hyperlipidemia, and Alzheimer ' s disease (a brain disorder that slowly damages memory and thinking skills). The admission record did not indicate that Resident 310 had a diagnosis of DM. During a review of Resident 301 ' s GACH 1 Admission History and Physical, dated 12/10/2024, indicated Resident 301 had a past medical history that included type 2 DM. During a review of Resident 301 ' s Medication Administration Record (MAR), from GACH 1, indicated Resident 301 was given insulin Lispro (treatment medication for high blood sugar levels) on 12/10/2024 at 9:20 PM; 12/11/2024 at 5:57 PM and 8:38 PM; 12/12/2024 at 5:58 PM and 10:20 PM; 12/13/2024 at 9:02 AM, 12:08 PM, and 5:45 PM; 12/15/2024 at 9:59 AM; 12/16/2024 at 12:24 PM and 5:24 PM; 12/17/2024 at 1:49 PM; 12/18/2024 at 8:36 AM, 12:15 PM, 5:04 PM and 9:21 PM; 12/19/2024 at 10:44 AM, 1:39 PM; 12/20/2024 at 6:24 PM; 12/21/2024 at 6:11 PM; and 12/28/2024 at 6:32 AM. During a review of Resident 301 ' s Admission Report Check List (ARCL, a communication form completed by the facility ' s Registered Nurse (RN) when receiving information from the GACH regarding a resident prior to admission to the facility), undated, indicated Resident 301 had a history of DM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 301 ' s Admission Notes, dated 1/2/2025, indicated Resident 301 was admitted on [DATE] at 5:45 PM with medical health history that included DM. During a review of Resident 301 ' s Initial Visit NP (Nurse Practitioner) Progress Note, dated 1/3/2025, documented by NP 2, there was no indication that Resident 301 had a history of type 2 DM. The note did not indicate to monitor Resident 301 ' s blood sugar level or to monitor for sign and symptoms of high blood sugar level (such as restlessness, feeling tired, excessive thirst) or low blood sugar level (such as weakness, dizziness or hungry). During a review of Resident 301 ' s Physician Admission Progress Note, dated 1/6/2025, indicated no documentation that Resident 301 had a history of DM, and there was physician note that indicate to monitor Resident 301 ' s blood sugar level or monitor for high or low blood sugar level. During a review of Resident 301 ' s care plans, indicated no care plan was developed to address interventions to address the resident ' s diagnosis of DM. During an observation on 1/7/2025 at 9:53 AM in Resident 301 ' s room, Resident 301 was lying in bed, connected with a tube feeding. Resident 301 ' s eyes were staring at the ceiling and Resident 301 was not able to answer any questions. During a review of Resident 301 ' s Nursing Progress Notes, dated 1/8/2025, documented by RN 1 at 10:14 AM, indicated per GACH 1 ' s record, Resident 301 was noted with history of type 2 DM and there was no medication ordered by the physician to treat DM, and RN 1 received an order from Nurse Practitioner (NP) 1 to monitor the resident ' s blood sugar. RN 1 documented she was informed by Resident 301 ' s family member (FAM)1 that Resident 301 was not diagnosed with DM prior to hospitalization to GACH 1, and the resident ' s blood sugar checked in the GACH with the result of around 151-154 milligrams (mg, unit of weight) per deciliter (dL, unit of volume) (a normal blood sugar level is between 70 and 100 mg/dL). The note also indicated, Resident 301 ' s blood sugar was checked, and the result was at 118 mg/dL. During a concurrent record review and interview on 1/8/2025 at 9:40 AM with RN 1, Resident 301 ' s GACH 1 ' s discharge packet and Resident 301 ' s ARCL form were reviewed. RN 1 stated, RN 3 was the one that received the report from GACH 1 and completed Resident 301 ' s ARCL form prior to admission that indicated Resident 301 had a history of type 2 DM. RN 1 stated, most GACHs sent their patients to the facility with H&P, lab works, Medication Administration Record (MAR) and discharge summary with continue/discontinue medications. RN 1 stated, she could not find Resident 301 ' s GACH 1 ' s physician orders and MAR to review. During a concurrent record review and interview on 1/8/2025 at 9:55 AM with RN 1, Resident 301 ' s physician orders was reviewed. RN 1 stated, there was no physician order for Resident 301 to be monitored for blood sugar, lab draw or treatment. RN 1 stated, RN 3 should have informed and verified with the doctor for Resident 301 ' s history of DM, especially when Resident 301 was on NPO (nothing by mouth) and on tube feeding. RN 1 stated, if Resident 301 ' s blood sugar monitoring and treatment was not needed, it should have been documented in the physician progress note. During an interview on 1/8/2025 at 10 AM with RN 1, RN 1 stated, she would notify Resident 301 ' s physician regarding Resident 301 ' s history of DM to obtain orders and would call Resident 301 ' s family member (FAM 1) for a change in the physician orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 1/8/2025 at 10:35 AM with the MDSN, Resident 301 ' s electronic medical record (EMR) did not have Resident 301 ' s diagnosis available for review since the resident was admitted to the facility 6 days ago. The MDSN stated, Resident 301 ' s diagnosis should be available for review in EMR within 24 hours after admission. The MDSN stated, the LVNs who has been taking care of Resident 301 would not know if Resident 301 had DM if they only review the information via EMR. During a concurrent record review and interview on 1/8/2025 at 10:45 AM with the MDSN, Resident 301 ' s GACH 1 ' s discharge packet was reviewed. The MDSN stated, based on GACH 1 ' s record, Resident 301 had a history of DM. The MDSN stated, she was not aware of Resident 301 ' s history of DM because she did not have a chance to review Resident 301 ' s GACH 1 ' s discharge packet. The MDSN stated, she created Resident 301 ' s care plan based on the information available via EMR and active physician orders without reviewing Resident 301 ' s discharge packet so she did not create a care plan to address Resident 301 ' s DM. During an interview on 1/8/2025 at 4:35 PM with Resident 301 ' s NP 1, NP 1 stated, when Resident 301 was admitted to the facility on [DATE], NP 1 was on vacation and NP 2 was covering for her. NP 1 stated, she came back and took over on 1/6/2025. NP 1 stated, she did not review Resident 301 ' s GACH 1 ' s discharge packet because NP 2 was supposed to review the documents during initial visit of the resident, the NP 1 stated, NP 2 did not inform her about Resident 301 ' s history of DM. NP 1 stated, FAM 1 informed her that Resident 301 ' s blood sugar was being monitored during hospital stay and insulin was given. NP 1 stated, if she was the NP that admitted Resident 301, she would have ordered blood sugar check, and some lab works to rule out DM and document them in her progress notes. During an interview on 1/9/2025 at 4:30 PM with the Director of Nurses (DON), the DON stated, the admitting RN should have thoroughly reviewed Resident 301 ' s discharge packet and clarified the orders and diagnosis. The DON stated, it should be documented in the physician progress note if the resident had history of DM and if they decided not to monitor for blood sugar and not to treat it. The DON stated, the facility did not have a policy and procedure guide for the RN to follow when admitting a resident to the facility. The DON stated, they did not have a list of GACH records that they expected the RN to review upon resident ' s admission. The DON stated, she trusted her RNs to know what GACH records to review and to request when some records were not sent with the resident. During a review of the facility ' s policy and procedure (P&P) titled, Physician visits, revised June 2019, indicated during the initial visit, the physician shall complete a thorough assessment, develop plan of care and writes or verifies admitting orders for the resident. During a review of the facility ' s P&P titled, Diabetes Mellitus Resident, Nursing Care of, revised November 2019, indicated the following: -It is the policy of the facility to assist the resident to establish a balance between diet/exercise and insulin, prevent recurrence of hypoglycemia, and recognize complications commonly associated with diabetes. -Diabetes Mellitus is defined as chronic hereditary or developmental disorder in which there is relative or absolute lack of insulin effect characterized by disturbed metabolism or glucose, fat, and/or protein. (continued on next page)

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	055430	A. Building B. Wing	01/10/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation may include the following: vital signs, pertinent laboratory studies including blood sugar. During a review of the facility ' s P&P titled, Documentation and Charting, revised May 2019, indicated it is the policy of the facility to provide resident ' s care, treatment, response to care, guidance to the physician in prescribing appropriate medications and treatments; a tool for measuring the quality of care provided to the resident; and assistance in the development of a Plan of Care for each resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012 Based on interview, observation, and record review, the facility failed to provide a properly place and sized knee immobilizer (a device typically used for injuries that benefit from immobilization but can tolerate brief periods without immobilization to help relief pain and healing) for one (Resident 351) out of three sample residents. As a result of this failure Resident 351 was at risk for injury, discomfort, and complications, such as impaired mobility and skin breakdown. Findings: During a review of Resident 351's Admission Record (Face Sheet), indicated the resident was admitted to the facility on [DATE], with diagnoses including fracture (a break in a bone) of the right patella (kneecap), and history of falling. During a review of Resident 351's History and Physical (H&P), dated 12/13/2024 indicated, Resident 351 had the mental capacity to make medical decisions. During a review of Resident 351's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 12/13/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and was dependent from the staff for the activities of daily living. During an observation on 1/6/2025 at 10 AM, Resident 351 was observed standing in the room without the prescribed knee immobilizer on her knee. The knee immobilizer was positioned at her ankle instead of providing support to her knee. Resident 351 stated, this happens a lot. The brace keeps sliding down, and it doesn't feel like it's helping much. During a concurrent observation and interview on 1/6/2024 at 10:28 AM, with Resident 351, Resident 351 room was observed sitting in a wheelchair with a knee immobilizer on the right leg. The immobilizer appeared loose, with visible gaps around the resident's knee and thigh. License Vocational Nurse 3 (LVN 3) confirmed during the observation that the immobilizer needed to be adjusted. During an interview on 1/7/2024 at 10:30 AM with LVN 3, stated the knee immobilizer must be properly positioned to provide stability and support to the knee and it is checked during rounds, LVN 3 stated it may have slipped, depending on the resident's movements. LVN 3 stated that there was no recent report had been made to therapy regarding the immobilizer slipping frequently. During an interview on 1/9/2024 at 4:35 PM with Physical Therapist (PT 1), stated having to adjust the immobilizer multiple times during therapy sessions to ensure it stayed in place. PT 1 stated, once it ' s properly strapped, it works, but the resident would benefit from a properly sized immobilizer. PT 1 stated that no action had been taken to order a replacement immobilizer. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/2024 at 4:35 PM with Director of Nursing (DON), DON stated that a properly fitting knee immobilizer is critical for stabilizing the joint, supporting mobility, and preventing further injury or strain. The DON stated, If the immobilizer is not the right size or improperly placed, it cannot provide the intended support and may lead to discomfort or even harm. It's essential that these issues are addressed promptly. DON stated that was no reports regarding the immobilizer's improper fit that had been communicated to nursing leadership, and no corrective actions were taken to obtain a properly sized replacement.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to provide interventions for safety and supervision for four of four sampled residents (Residents 29, 56, 89, and 154), who were at risk for elopement (an incident where a resident leaves the facility unsupervised and without staff knowledge). These deficient practices put Resident 29, 56, 89, and 154 at risk of elopement and potentially lead to serious injury and irreversible harm. Findings: a. During a review of Resident 56's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone, can disrupt heart rate, body temperature and all aspects of metabolism), and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities). During a review of Resident 56's History and Physical (H&P), dated 9/27/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 56's MDS, dated [DATE], indicated the resident had moderately impaired cognitive skills for decision making. During a review of Resident 56's Elopement/Wandering Evaluation dated 10/2/2024 indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 56's care plans on 1/10/2025 at 9:56 AM, MDS Nurse (MDSN) stated Resident 56's care plan for elopement was created on 1/7/2025. MDSN stated she could not find documented evidence of a care plan or interventions created after Resident 56 was evaluated for elopement/wandering on 10/2/2024. MDSN stated the purpose of the care plan is to take care of the resident and it was the staff's guide to improve or address any issues that the resident has. MDSN stated she added the care plan for elopement because resident was at high risk for elopement. MDSN stated she was unsure why the care plan was not created after 10/2/2024. MDSN stated if a care plan was not created, no interventions were in place. During an interview with the Medical Records Director (MRD) on 1/10/2025 at 12:20 PM, MRD stated she could not find elopement/wandering risk documented in Resident 56's Interdisciplinary Team's (IDT) record for care planning. b. During a review of Resident 154's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included disorders of urinary system, interstitial pulmonary diseases (group of disorders that cause progressive scarring of lung tissue), and Alzheimer's disease. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 154's MDS, dated [DATE], indicated the resident had moderately impaired cognition. During a review of Resident 154's Elopement/Wandering Evaluation dated 12/25/2024 indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 154's care plans on 1/10/2025 at 10:29 AM, the Social Services Assistant (SSA) stated she met with Resident 154 on 1/7/2025. SSA stated Resident 154 seemed like a flight risk which was someone that can possibly leave the facility. SSA stated she did not review Resident 154's elopement risk assessment. SSA stated she created the care plan for elopement on 1/7/2025 because Resident 154 verbalized during the conversation she wanted to go home. SSA stated she could not recall if she documented the conversation. During an interview with the Medical Records Director (MRD) on 1/10/2025 at 12:20 PM, MRD stated she could not find documented evidence of elopement/wandering risk in Resident 154's Interdisciplinary Team (IDT) care planning. c. During a review of Resident 89's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included anemia (condition in which the blood doesn't have enough healthy red blood cells and hemoglobin [a protein found in blood cells] to carry oxygen all through the body), difficulty walking, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 89's History and Physical (H&P), dated 9/14/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 89's MDS, dated [DATE], indicated the resident ' s cognition as intact. During a review of Resident 89's Elopement/Wandering Evaluation dated 9/4/2024 indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 89's care plans on 1/10/2025 at 10:40 AM, the Assistant Director of Nursing (ADON) stated she was reviewing Resident 89's chart and a care plan for elopement on 1/7/2025. The ADON stated she could not find care plan or interventions created and documented after Resident 89 evaluated at high risk of elopement/wandering on 9/4/2024. During an interview with the Medical Records Director (MRD) on 1/10/2025 at 12:20 PM, MRD stated she could not find elopement/wandering risk documented in Resident 89's Interdisciplinary Team's (IDT) record for care planning. d. During a review of Resident 29's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included senile degeneration of brain, encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), and muscle weakness. During a review of Resident 29's History and Physical (H&P), dated 10/18/2024, indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/16/2024, indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 29's Elopement/Wandering Evaluation dated 11/16/2024 indicated resident was at high risk for elopement/wandering. During a concurrent interview and record review of Resident 29's care plans on 1/10/2025 at 10:41 AM, the Assistant Director of Nursing (ADON) stated Resident 29's care plan for elopement was created on 1/8/2025. The ADON stated she could not find documented evidence of a care plan or interventions created after Resident 29 was evaluated for elopement/wandering on 11/16/2024. The ADON stated Resident 29 should have an active elopement care plan because she was at high risk for elopement. The ADON stated the care plan should include interventions to prevent elopement. During an interview with the Director of Nursing (DON) on 1/10/2025 at 10:54 AM, the DON stated it was important to develop a care plan for residents at risk for elopement so there are interventions to prevent elopement from happening. The DON stated the care plan should have been created as soon as facility knew resident was at risk. The DON stated if there was no care plan there was a possibility the resident could elope. The DON stated she expects the staff to review the elopement assessment and to create a care plan. The DON stated if there were any instances of eloping it should be documented in the progress notes. During an interview with the Medical Records Director (MRD) on 1/10/2025 at 12:20 PM, MRD stated she could not find elopement/wandering risk documented in Resident 29's Interdisciplinary Team's (IDT) record for care planning. During a review of the facility's policy and procedure (P&P) titled Elopement/Unsafe Wandering revised on 12/2023 indicated the facility will provide a safe environment as free of accidents as possible for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. The P&P indicated residents with high risk factors will be identified as At Risk and will have an individualized care plan developed that includes measurable objectives and time frames. The P&P indicated care plan interventions will consider the elements of the evaluation or behavior observations that identified the resident at risk. The P&P also indicated interventions will address the individualized level of supervision needed to prevent elopement/unsafe wandering.

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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. 50012 Based on observation, interview, and record review, the facility failed to ensure one out of three sampled residents (Resident 136) who was identified as at risk for weigh loss, received the prescribed health shake (a nutritional supplement) TID (three times a day) as ordered by the physician. This failure had the potential to result in further weight loss and dehydration (fluid deficit) that could lead to compromised nutritional status and overall, well being. Findings: During a review of Resident 136 ' s Admission Record, the facility admitted Resident 136 on 10/23/2024, with diagnoses including hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and difficulty in walking. During a review of Resident 136 ' s History and Physical (H&P), dated 10/23/2024 indicated, Resident 132 can make needs known but cannot make medical decisions. During a review of Resident 136's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/25/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and needed supervision to extensive assistance from the staff for the activities of daily living. During a review of Resident 136's Order Summary Report, dated 1/8/2025, the Order Summary Report dated 11/27/2024 indicated to provide Resident 136 with Fortified diet (a diet that includes foods that have had nutrients added to them.) Regular texture, thin liquids consistency, Health Shakes TID with meals. During a review of Resident 136 ' s care plan, dated 10/23/2024, indicated Resident 136 was at risk for nutritional problem, weight loss/fluctuation (to change or move back and forth), at risk for malnutrition (poor food intake) indicated Resident 136 was at risk for s/s (signs and symptoms) of dehydration r/t (related to) therapeutic diet, s/p (status post) fall secondary to syncope (loss of consciousness), multiple Right Rib fx (fracture- broken bone) no surgery, acute respiratory failure (difficulty breathing), HTN (hypertension), HLD(Hyperlipidemia) , hypothyroid (thyroid gland doesn ' t make or release enough hormone into your bloodstream), Atrial Fibrillation (irregular heartbeat), dementia (a disorder of mental processes caused by brain disease or injury and marked by memory disorder, personality changes, and impaired reasoning) , anxiety, rhabdomyolysis (condition that causes your muscles to break down), diuretic (increases flow of urine) medication use. The care plan goal indicated Resident 136 will maintain adequate nutritional status as evidenced by maintaining weight with no s/s of malnutrition through review date. The care plan interventions included to provide Health shakes 4oz TID with meals. During a concurrent observation and interview on 1/8/2025 at 12:45 PM, with Family member 1 (FM1) of Resident 136, in Resident 136 ' s room, observed meal tray did not include the prescribed health shake. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/8/2025 at 12:45 PM, Family Member 1 (FM1) of Resident 136 was present in Resident 136 ' s room. The resident's meal tray, observed at that time, did not include the prescribed health shake. The meal ticket accompanying the tray indicated that a health shake should be included with the meal. FM1 stated, that Resident 136 did not receive the health shake with her meal. During a concurrent observation and interview on 1/8/2025 at 12:50 PM, with Registered Nurse 1 (RN 1) in Resident 136 ' s room, RN 1 confirmed that the health shake was not on the meal tray and requested it from the kitchen after the oversight was identified. RN 1 stated, she shouldn ' t skip the shake, as it ' s essential for addressing her recent weight loss. During an interview on 1/9/2025 at 4:06 PM with Dietary Supervisor (DS), stated Resident 136 does have a physician order to receive the health shake with her meals three times a day. It must have been missed accidentally. DS stated the shakes are essential for residents with weight loss to maintain proper nutrition and prevent further health complications. During an interview on 1/10/2025 at 12:45 PM with the Director of Nursing (DON), DON stated, it was important to ensure the residents receive prescribed dietary supplements, follow the physician ' s diet orders for the residents to maintain the nutritional health, especially for those with weight loss concerns. Nutritional supplements like health shakes are a key component of their care plan and must be provided as ordered to prevent further decline. During a review of the facility's policy and procedure (P&P) titled, Diet Orders, revised 2023, indicated that Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to ensure three (3) of 3 sampled residents (Resident 27, 201, and 202) were provided with safety and comfort while receiving oxygen therapy, in accordance with the facility's policy and procedure by failing to: 1. Ensure Resident 27's oxygen tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient ' s ears) and nasal cannula did not touch the floor. 2. Ensure Resident 201's humidifier bottle (a water bottle that aids in preventing patients' airways from becoming dry) was not empty for Resident 201. 3. Ensure Resident 202's oxygen tubing did not touch the floor. These deficient practices had the potential for Resident 27, 201, and 202 to contract infection while receiving oxygen therapy and increase the risk of the spread of infection to other residents, staff, and the visitors in the facility. Findings: 1. During a review of Resident 27's Admission record indicated the resident was admitted on [DATE] with diagnoses that included lobar pneumonia (type of pneumonia characterized by the infection and inflammation of one or more lobes of the lung), difficulty in walking, type 2 diabetes mellitus (long-term medical condition in which your body doesn't use insulin (hormone that helps body turn food into energy and controls blood sugar levels) properly, resulting in unusual blood sugar levels) with diabetic neuropathy (nerve damage that can occur with diabetes), and dependence on renal dialysis. During a review of Resident 27's History and Physical (H&P), dated 10/25/2024, indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 27's Order Summary Report, dated 12/28/2024, indicated a physician order for Oxygen therapy at 2 liters (L, unit of measure) per minute continuous every shift. During an observation in Resident 27's room on 1/6/2025 at 9:59 AM, Resident 27's nasal cannula (medical device to provide supplemental oxygen therapy) and oxygen tubing was observed on the floor. During a concurrent observation and interview in Resident 27's room on 1/6/2025 at 10:15 AM, the Assistant Director of Nursing (ADON) was observed placing a floor mat on the right side of resident ' s bed and on top of resident's nasal cannula and oxygen tubing. At 10:20 AM, verified with ADON of Resident 27's nasal cannula and tubing placement on the floor. ADON stated when not in use, the nasal cannula and tubing suppose to be placed in the bag for infection control. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 201's Admission record indicated the resident was admitted on [DATE] with diagnoses that included lobar pneumonia, sepsis (a serious condition in which the body responds improperly to an infection), and acute erythroid leukemia (an extremely rare form of acute myeloid leukemia [type of cancer of the blood and bone marrow with excess immature white blood cells] which is characterized by neoplastic proliferation [the process of excessive and uncontrolled cell proliferation] of erythroid cells [red blood cells]) in relapse. During a review of Resident 201's History and Physical (H&P), dated 12/26/2024, indicated the resident had capacity to understand and make decisions. During a review of Resident 201's Order Summary Report, dated 12/28/2024, indicated a physician order for Oxygen therapy at 2 liters (L, unit of measure) per minute as needed for shortness of breath or Oxygen saturation level less than 92%. The Order Summary Report also indicated a physician order to change oxygen humidifier every day shift every 7 day(s) and to change every Thursday. During an observation in Resident 201's room on 1/6/2025 at 10 AM, Resident 201 was observed receiving oxygen therapy via nasal cannula at 3 LPM. Observed nasal cannula and oxygen tubing attached to oxygen machine with an empty humidifier bottle dated 12/26/2024. During a concurrent observation and interview in Resident 201's room [ROOM NUMBER]/6/2025 at 10:22 AM, verified with ADON of the empty humidifier bottle attached to Resident 201's oxygen machine. ADON stated the humidifier bottle should be changed every week. 3. During a review of Resident 202's Admission record indicated the resident was admitted on [DATE] with diagnoses that included pulmonary embolism without acute pulmonale, type 2 diabetes mellitus, and essential hypertension (high blood pressure). During a review of Resident 202's History and Physical (H&P), dated 1/8/202, did not indicate if the resident had capacity to understand or make decisions. During a review of Resident 202's Order Summary Report, dated 1/2/2025, indicated a physician order for Oxygen therapy at 2 LPM continuous every shift. During an observation in Resident 202's room on 1/6/2025 at 11:07 AM, Resident 202 was observed receiving oxygen therapy via nasal cannula at 2 LPM. Observed Resident 202's oxygen tubing touching the floor. During a concurrent observation and interview in Resident 202's room [ROOM NUMBER]/6/2025 at 11:21 AM, verified with licensed vocational nurse (LVN) 1 of Resident 202's oxygen tubing. LVN stated the oxygen tubing should not be on the floor to prevent spread of infection. LVN stated she would change the oxygen tubing and humidifier bottle because there was no date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 1/10/2025 at 11:05 AM, the DON stated oxygen equipment should not be touching the floor because there was a concern for infection control. The DON stated the oxygen equipment should be replaced right away. The DON stated when not in use, the oxygen tubing and nasal cannula should be placed in a plastic bag with a date of when it was opened. The DON stated the humidifier bottle should be changed every 7 days or when it was empty. The DON stated the humidifier bottle should not be empty because it could cause nose to dry up if there was a high concentration of oxygen being given. The DON stated the humidifier bottle should also be labeled of when it was opened. During a review of the facility's policy and procedure (P&P) titled Oxygen, use of dated 5/2021 indicated the facility will promote resident safety in administering oxygen. The P&P indicated tubing, masks, humidifiers, and other disposables used for Oxygen administration will be dated in an identifiable fashion. The P&P indicated the tubing should be kept off the floor. The P&P also indicated labeled and dated bags should be provided for cannulas and masks to be placed in when not in use.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview, and record review, the facility failed to follow the facility's policy and procedure titled, Physician visits, by failing to ensure Nurse Practitioner (NP) 1 thoroughly reviewed the overall care needed including the hospital record for one of thirty sampled residents (Resident 301) who had a history of type 2 Diabetes Mellitus (DM, a condition of having high blood sugar) that was not monitored for blood sugar levels. The failure had a potential to result in the resident to have uncontrolled blood sugar level that could lead to hospitalization or death. Cross reference to F684, F867 Findings: During a review of Resident 301's Admission Record, indicated Resident 301 was admitted to the facility on [DATE] with diagnosis that included hemiplegia (a condition that causes weakness or loss of the ability to move on one side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, hyperparathyroidism, hyperlipidemia, and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). During a review of Resident 301's GACH 1 Admission History and Physical, dated 12/10/2024, indicated Resident 301 had a past medical history that included type 2 DM. During a review of Resident 301's Admission Report Check List (a communication form where the facility's Registered Nurse (RN) receives information from GACH 1's RN regarding a resident that would be admitted to the facility, undated, indicated Resident 301 had a history of DM. During a review of Resident 301's Admission Notes, dated 1/2/2025, indicated Resident 301 was admitted on [DATE] at 5:45 PM with medical health history that included DM. During a review of Resident 301's Initial Visit NP (Nurse Practitioner) Progress Note, dated 1/3/2025, did not indicate Resident 301 had a history of DM and if the blood sugar was monitored. During a review of Resident 301's Physician Admission Progress Note, dated 1/6/2025, indicated did not indicate Resident 301 had a history of DM and there was no indication if the blood sugar was monitored. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/2025 at 4:35 PM with Resident 301's NP 1, NP 1 stated, when Resident 301 was admitted to the facility on [DATE], NP 1 was on vacation and NP 2 was covering for her. NP 1 stated, she came back and took over on 1/6/2025. NP 1 stated, she did not review Resident 301's GACH 1's discharge packet because NP 2 was supposed to review the documents during initial visit of the resident, the NP 1 stated, NP 2 did not inform her about Resident 301's history of DM. NP 1 stated, FAM 1 informed her that Resident 301's blood sugar was being monitored during hospital stay and insulin (medication to lower blood sugar) was given. NP 1 stated, if she was the NP that admitted Resident 301, she would have ordered blood sugar check, and some lab works to rule out DM and document them in her progress notes. During an interview on 1/9/2025 at 4:30 PM with the Director of Nurses (DON), the DON stated, NP 1 should have reviewed Resident 301's hospital record and clarify the diagnosis and orders when NP 1 took over the care of Resident 301. During a review of the facility's policy and procedure titled, Physician visits, revised June 2019, indicated during the initial visit, the physician shall complete a thorough assessment, develop plan of care and writes or verifies admitting orders for the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview and record review, the facility failed to reseal one intramuscular emergency kit (IM e-kit, a collection of supplies of medications that administered into the muscle in an emergency) for one of three sampled IM e-kits and replace the e-kit within 72 hours for Medication room [ROOM NUMBER]. The deficient practice had potential to result in an insufficient number of medications on hand in case of emergency and the potential to result in the inability to identify drug diversion (when a medication is taken for use by someone other than whom it was prescribed or for an indication other than what is prescribed) or misuse. Findings: 1. During a review of Resident 251's Admission Record indicated the facility originally admitted Resident 251 on 4/16/2024 and readmitted him on 12/2/2024 with diagnoses that included diabetes mellitus (a group of diseases that result in too much sugar in the blood) and hyperlipidemia (a condition where there are high levels of fat in the blood). During a review of Resident 251's Minimum Data Set (MDS, a resident assessment tool), dated 12/9/2024, indicated Resident 251 had intact memory and cognition (ability to think and reason). During a review of the facility's IM/E-KIT log, dated 9/30/2024, indicated one vial of furosemide 40 mg/ four milliliter (ml, a unit of measurement) was available and it was removed from the e-kit on 12/5/2024 at 4:20 PM and used for Resident 251. During a review of Resident 251's Order Details, dated 12/5/2024, indicated the physician ordered to give Furosemide (a medication to treat fluid retention) 40 milligrams (mg, a unit of measurement) intramuscularly one time only on 12/5/2024. During a review of Resident 251's Medication Administration Record (MAR), dated 12/1/2024 to 12/31/2024, indicated Resident 251 received Furosemide 40 mg inject intramuscularly one time only, dose from e-kit, on 12/5/2024. 2. During a review of Resident 48's Admission Record indicated the facility originally admitted Resident 48 on 5/22/2022 and readmitted him on 5/30/2024 with diagnoses that included diabetes mellitus and hyperlipidemia. During a review of Resident 48's MDS, dated [DATE], indicated Resident 48 had severely impaired memory and cognition. During a review of the facility's IM/E-KIT log, dated 9/30/2024, indicated 1 unit of Glucagon Hypo kit (a prescription emergency kit that contains glucagon, a hormone that treats severe low blood sugar in people) 1 mg was available and it was removed from the e-kit on 12/30/2024 at 11 PM and used for Resident 48. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review Resident 48's Order Summary order, dated 12/18/2024, indicated the physician ordered if blood sugar level was less than 70 and conscious or no change in level of conscience, give Insta-Glucose (a gel that can raise blood sugar level quickly) orally one time, recheck blood sugar level after 15 minutes, if ineffective and or unconscious, give Glucagon 1mg IM one time. During a review of Resident 48's Progress Notes, dated 12/30/2024, indicted skilled nurse administered Glucagon IM due to low blood sugar level. During an interview and concurrent observation on 1/8/2025 at 2:48 PM of Medication room [ROOM NUMBER] with Registered Nurse (RN)1, One IM e-kit was observed opened with no zip tie (a fastener consisting of a thin flexible nylon strap). RN 1 stated the IM e-kit was missing the Furosemide (a medication used to reduce water retention). RN 1 stated she did not know why she did not know why and for how long the IM e-kit was not resealed with the orange zip ties when the medication was taken out to prevent unauthorized access to the e-kit and to let the pharmacy know the e-kit had been opened and needed to be replaced. During a telephone interview on 1/9/2025 at 10:17 AM, with the Pharmacist. The Pharmacist stated the facility started to implement the use of CUBEX (an automated unit dose system for storage and retrieval of unit doses of drugs for administration to patients) for emergency supply of medications on 12/20/2024 and the facility was expected not to use the e-kits anymore. The pharmacist stated the pharmacy staff went to pick up all the physical e-kit boxes from the facility on 1/4/2025, but the facility did not turn in the IM e-kit on that day. The pharmacist stated they were not aware that the facility still had the e-kit and was still using it, so they did not replace the e-kit. During an interview on 1/9/2025 at 1:50 PM, with the Director of Nursing (DON), the DON stated if the nurse opened the e-kit and used medication from the e-kit, the nurse should reseal the e-kit with the orange zip ties, so that no one else could get the access to the e-kit and remove medications from it without authorization and alert other staff a replacement of the e-kit was needed. The DON stated it was important to have emergency supply of medications available to ensure the patient received the medication when needed. The DON stated after 12/20/2024, the facility started to use CUBEX for the emergency supply of medications and did not need to use the e-kit anymore, but she did not know why the staff still opened the e-kit and removed medication from it for a patient on 12/30/2024. During a review of the undated facility's policy and procedure (P&P) titled, Emergency Pharmacy Service and Emergency Kits, indicated an emergency supply of medications, .are supplied by the provider pharmacy in limited quantities in portable, sealed containers, . and When an emergency or starter dose of a medication is needed, the nurse unlocks the container/cabinet, .As soon as possible, the nurse seals the E kit with a color-coded lock to indicate need for replacement of the E kit. The P&P also indicated opened kit are replaced 72 hours of opening.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview and record review the facility used higher than necessary dose of Ativan (a medication used to treat anxiety) for one three sampled residents (Resident 73) who did not present or display with any behaviors of anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). This deficient practice put Resident 73 at risk of experience adverse effects of psychotropic medication therapy including, but not limited to, dizziness, drowsiness, loss of coordination leading to an overall negative impact to their physical, mental and psychosocial well being. Findings: During a review of Resident 73's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included Generalized Anxiety disorder (a mental health condition characterized by excessive persistent and uncontrollable worry and tension), Anemia (a problem of not having enough healthy red blood cells). During a review of Resident 73's History and Physical (H&P) dated 1/03/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 73's Psychiatric Gradual Reduction Progress Note dated 12/23/2024, indicated Dose reduction recommended: As needed Ativan/Ambien for 30 days. During a review of Resident 73's Order Summary Report dated 12/31/2025, indicated a physician order for: 1. Ativan oral tablet 0.5 milligram (mg-a unit of measurement) give 1 tablet by mouth every 6 hours as needed for anxiety manifested by verbalization of anxiousness. With a start date of 12/24/24 and no end date. 2. Ativan oral tablet 1 mg, give 1 mg by mouth two times a day for Anxiety manifested by verbalizations of anxiousness, with s start date of 12/24/2024. During a review of Resident 73's Medication Administration Record (MAR - a record of medications, behaviors, and adverse effect monitoring done by licensed nursing staff) for December 2024 indicated monitoring for episodes of anxiety verbalization of anxiousness every shift for 12/1/2024 - 12/31/2024 : The record indicated 0 (indication of no episodes of anxiety) for month of December (all 3 shifts - morning, evening and night). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's Medication Administration Record (MAR - a record of medications, behaviors, and adverse effect monitoring done by licensed nursing staff) for January 2025 indicated monitoring for episodes of anxiety verbalization of anxiousness the record indicated 0 for all shifts from 1/1/2025 - 1/08/2025. During a review of Resident 73's Progress notes dated 12/24/2024 timed at 2:10 AM authored by Registered Nurse 2 (RN 2), indicated Resident 73 was seen and evaluated by Psychiatric Nurse Practitioner with new written orders: 1. Discontinue Ambien 10mg routinely 2. Ambien 10 mg every night as needed for 30 days 3. Discontinue Ativan routinely 4. Ativan 0.5mg -1 tablet by mouth every 6 hours as needed for verbalization of anxiousness for 30 days Resident 73 and Nurse Practitioner made aware and in agreement. Orders noted and carried out then communicated with staff. During a review of Resident 73's Progress notes dated 12/24/2024 timed at 9:55 AM authored by Assistant Director of Nursing (ADON), indicated Resident 73 complained of Ativan dose changed from 1mg twice a day to 0.5 mg as needed every 6 hours, and requested to change back to old order. Nurse Practitioner notified and agreed to change it back to Ativan 1mg twice a day. During an interview with Psychiatric Nurse Practitioner (PNP), PNP stated she had visited the facility in December to conduct her regular drug regimen review for the Residents of the facility. PNP stated that day she reviewed Resident 73's medication and decided to reduce Resident 73's Ativan 1mg routinely to Ativan 0. 5 mg as needed based on her assessment of Resident 73 and review of Resident 73's nursing notes and behavior monitoring by facility which indicated Resident 73 did not have any behaviors of Anxiety for the month of December. PNP stated Resident 73 is a very alert Resident who she talked to and explained the plan of changing the dosage to which Resident 73 agreed upon on and was aware. PNP stated the next day she received a telephone call from facilities ADON stating Resident 73 was asking to have his Ativan medication changed back from as needed to routinely and increased the dose from 0.5mg to 1 mg. PNP stated she did not come into the facility to reassess Resident 73 or speak she authorized medication to be changed back since Resident 73 was asking for it. During an interview on 1/10/2025 at 8:32 AM with Resident 73, Resident 73 stated his Ativan medication had been changed at the end of last month but was now back to being routinely. Resident 73 stated the day after the PNP came to see him last month he asked the licensed nurse who was giving his medication for an Ativan. Resident 73 stated the nurse told him He could not have one because the doctor had changed the order because he could overdose on the medication and that the state was bugging the facility, and they did not want to get in trouble with the state. Resident 73 stated he felt mislead by PNP who had told him he would still be able to get his Ativan medication if he needed. Resident 73 stated later that day a nurse from the facility told him they would change back the order to the way it was. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Psychotropic Medications dated with a revised date of 12/2023 indicated It is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drug unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medications shall not be administered for the purpose of discipline or convenience.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50012 Based on observation and interview, the facility failed to ensure the daily refrigerator temperature logs was completed as required by its policy, compromising its ability to monitor food storage temperatures effectively. This deficiency created a risk of unsafe food storage conditions and potential foodborne illness (caused by consuming contaminated foods or beverages) for residents. Findings: During initial kitchen tour with the Dietary Director (DD) on 1/6/2025 8:30 AM, observed that the refrigerator temperature logs located in the kitchen in a binder were incomplete. No temperature entries were documented for 1/4/2025 for AM and PM shift for Freezer #1. During a concurrent interview and record review on 1/7/2025 at 8:35 AM with the DD, the Refrigeration and Freezer Temperature Log for January 2025 was reviewed. The log had missing entries were noted for the AM and PM shift on 1/4/2025. The DD stated she should have followed up the completion of the log. During an interview on 1/7/2025 at 8:35 AM with the DS stated, Staff are expected to record refrigerator Temperatures are checked twice a day as part of our food safety protocols. Without these logs, we have no way of knowing if food has been stored at safe temperatures, which could lead to food spoilage or bacterial growth. If residents consume spoiled food, they could develop foodborne illnesses. During a review of the facility's policy and procedure (P&P) titled, Cold Storage temperature monitoring and record keeping , indicated, Food and Nutrition staff shall review and record temperatures of all refrigerators and freezers to ensure at the correct temperature for food storage and handling.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on interview, and record review, the facility ' s Quality Assessment and Assurance (QAA) committee (a group of facility staff responsible in developing and approving and evaluating established policies and procedures of resident ' s quality of care) failed to develop a policy and procedure related to admission process. Resident 301 was admitted to the facility with diagnosis of Diabetes Mellitus (a condition of having high blood sugar) at General Acute Care Hospital (GACH) 1, which was not monitored for signs and symptoms of high or low blood sugar levels. This failure had a potential for the residents not to receive the care and services for DM and other health concerns that could lead to a decline in the resident's well being. Cross reference to F684, F711 Findings: During a review of Resident 301's Admission Record, indicated Resident 301 was admitted to the facility on [DATE] with diagnosis that included hemiplegia (a condition that causes weakness or loss of the ability to move on one side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, hyperparathyroidism, hyperlipidemia, and Alzheimer's disease (a brain disorder that slowly damages memory and thinking skills). During a review of Resident 301's GACH 1's Admission History and Physical, dated 12/10/2024, indicated Resident 301 had a past medical history that included type 2 DM. During a review of Resident 301's Admission Report Check List (a communication form where the facility's Registered Nurse (RN) receives information from GACH 1's RN regarding a resident that would be admitted to the facility, undated, indicated Resident 301 had a history of DM. The form did not have a prefilled area with questions to remind the RNs to ask for the results of the last vital signs including blood sugar check and if insulin was given. During a review of Resident 301's Nursing Progress Notes, dated 1/8/2025, indicated per GACH 1's record, The note indicated, Resident 301's blood sugar check was around 151-154 milligrams (mg, unit of weight) per deciliter (dL, unit of volume) (a normal blood sugar level is between 70 and 100 mg/dL) while she was in GACH 1. The note indicated, Resident 301's blood sugar was checked, and the result was at 118 mg/dL. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/2025 at 9:40 AM with RN 1, RN 1 stated when admitting a resident to the facility, the RN would receive report from the hospital nurse and complete a report form. RN 1 stated, when the resident arrived, the admitting RN would review the hospital record chart including H&P, diagnosis, medications, and report to the doctor for medical history, medications, and orders. RN 1 stated, based on Resident 301's medical history from GACH 1, Resident 301 had a history of type 2 DM. RN 1 stated, she did not see any order for blood sugar monitoring or any physician progress notes that indicating blood sugar monitoring and treatment were not needed. RN 1 stated, most hospitals sent their patients to the facility with H&P, lab works, Medication Administration Record (MAR) and discharge summary with continue/discontinue medications. RN 1 stated, Resident 301's GACH 1 did not include the resident's MAR and orders during the hospital stay. During the same interview with RN 1, RN 1 stated, there was no written procedure guides or check list of the hospital records that they need to make sure to review during the admission process. RN 1 stated, they had an Admission Report Check List form where they filled in with the information reported by the hospital RN prior to the resident's transfer from the hospital to their facility. RN 1 stated, the admission check list form did not include a section to remind the RN to ask for the last vital signs, blood sugar check, or if insulin (medication for high blood sugar levels) was given during the hospital stay. During an interview on 1/9/2025 at 4:30 PM with the Director of Nurses (DON), the DON stated, the facility did not have a policy and procedure guide for the RNs to follow when admitting a resident to the facility. The DON stated, they did not have a list of hospital records that they expected the RN to review upon resident's admission. The DON stated, she trusted her RNs to know what hospital records to review and to request when some records were not sent with the resident. During a review of the facility's policy and procedures titled, Quality Assurance and Performance Improvement, revised January 2022, indicated the facility will establish and implement a Quality Assessment and Assurance Committee, develop a written Quality Assurance and Performance Improvement Plan, which will be used to continually assess the facility's performance using a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality. QAPI Plan Components will include the design and scope to include clinical care, address all systems of care and management practices.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to maintain a safe, sanitary environment to help prevent infection transmission (when a disease-causing microorganism (pathogen) moves from an infected person or animal to a susceptible host) spread to residents, staff members, visitors in accordance with the facility's policy and procedure on infection control by failing to: 1a. Ensure a contact isolation precaution (containing one in an area prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or resident's environment) signage was placed at entrance of Resident 204's room. 1b. Ensure Resident 204's family member (Family) 1 wore personal protective equipment (PPE) that included an isolation gown (gown used to protect clothing from contaminants or contacting disease causing organism) and gloves while in the room of Resident 204, who was under contact isolation precautions. 2. Ensure Resident 3's foley catheter bag did not touch the floor. These deficient practices had the potential to increase the spread of infection to other residents, staff, and visitors in the facility. Findings: 1. During a review of Resident 204's Admission record indicated the resident was admitted on [DATE] with diagnoses that included pneumonia (infection in the lungs caused by bacteria, viruses, or fungi), chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe) with exacerbation (worsening of a disease or an increase in its symptoms), and acute respiratory failure (a condition where one does not have enough oxygen in the tissues of the body (hypoxia) or when there is too much carbon dioxide in the blood (hypercapnia) with hypoxia. During a review of Resident 204's History and Physical (H&P), dated 12/20/2024, indicated the resident had capacity to understand and make decisions. During a review of Resident 204's Order Summary Report dated 1/9/2025, indicated a physician order for: a. Valacyclovir hydrochloride (medication used to treat herpes [virus cause contagious sores most often around the mouth or on the genitals] virus infection, including shingles [viral infection that causes a painful rash], cold sores, and genital herpes) Oral Tablet give 1000 milligrams (mg, unit of measurement) by mouth every 8 hours for Shingles for 7 days. b. Contact Isolation due to Shingles (a viral infection that causes a painful rash with blisters). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in the hallway near Resident 204's room with the Infection Prevention Nurse (IPN) on 1/9/2025 at 1:10 PM, no contact isolation precaution signage was observed at entrance of Resident 204's room. Family 1 was observed in Resident 204's room without wearing an isolation gown. During an interview with Family 1 on 1/9/2025 at 1:12 PM, Family 1 stated he did not see the isolation cart with gowns. Family 1 stated he wore a surgical mask and gloves as a precaution, but he was not aware that he had to wear an isolation gown. IPN informed Family 1 that he had to wear an isolation gown to protect himself not to infected by 204. During an interview with the IPN on 1/9/2025 at 1:17 PM, IPN stated it was the responsibility of herself and the nurses to make sure there was proper signage prior to entering Resident 204's room. IPN stated the Contact isolation precaution signage was important because it prompts the visitor or whoever was entering the room to ask for assistance and wear the correct personal protective equipment (PPE). IPN stated it was important for visitors and staff to wear the correct PPE so they do not get exposed to the infection. During an interview with the Director of Nursing (DON) on 1/10/2025 at 11:07 AM, the DON stated visitors should be educated to wear PPE before entering a resident room with contact precautions. The DON stated the importance of wearing PPE is to prevent infection. During a review of the facility's policy and procedure (P&P) titled Infection Prevention Control Program (ICPC) and Transmission-Based Precautions (TBP) revised date on 10/2022 indicated all residents who have another infection or condition for which contact isolations is recommended, PPE must be used in any room entry. The P&P indicated the required PPE for contact isolation includes gloves and gown, to don before room entry, and doff before room exit. The P&P also indicated the facility will implement a system to alert staff, residents, and visitors that a resident is on TBP that includes to post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gown and gloves). During a review of the facility's contact precautions signage dated 8/2021 indicated STOP, see nurse before entering room; clean hands-on room entry, wear a gown on room entry, wear gloves on room entry and clean hands when exiting. 42878 2. During a review of Resident 3's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance), chronic obstructive pulmonary disease (a diseases that blocks airflow and make it hard to breathe). During a review of Resident 3's History and Physical (H&P) dated 12/24/2024, the H&P indicated the resident has the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Order Summary Report dated 1/10/2025, indicated a physician order for a right lower quadrant abdomen urostomy (a surgical procedure which creates an opening in the abdomen through which urine drains from the body) attached to a drain foley bag (a collection bag that receives urine drained through a catheter), and change the bag on the 3rd day and as needed if dislodged. During a concurrent observation and interview on 01/08/2025 at 11:31 AM with Licensed Vocational Nurse (LVN)2 in Resident 3's room, Resident 3's foley bag was observed hanging from Resident 3 ' s bed left side rail touching the floor. LVN 2 stated the Foley bag should never be touching or laying on the floor as the floor is dirty and could contaminate and make Resident 3 sick. During an interview with the Director of Nursing (DON) on 1/10/2025 at 2:07 PM, the DON stated foley catheter bags should never be touching the floor, it is facility policy to keep off the floor to prevent any cross contamination from the floor to the Resident. During a review of the facility's policy and procedure (P&P) titled Catheter Drainage Bag dated revised on 05/2007 indicated 8. Position the drainage bag below the level of the resident's bladder and the drainage bag should be kept off the floor. During a review of the facility's policy and procedure (P&P) titled Catheter Drainage Bag dated revised on 05/2007 indicated to position the drainage bag below the level of the resident's bladder and the drainage bag should be kept off the floor.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467 Based on observation, interview, and record review, the facility failed to: 1. Provide sanitary environment for Resident 122 by ensuring an unknown black back brace (a braced used when moving or lifting residents from sitting to standing) was not found in the resident's room on 1/7/2025. This deficient practice had a potential to result in cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) when used by Resident 122 and other facility's residents. 2. Maintain a safe, functional door with locks that latch which leads to the patio area to maintain a safe environment for all residents and staff. This deficient practice had a potential to put the facility's residents and staffs at risk of injury and harm. Findings: 1. During a review of Resident 122's Admission Record, indicated Resident 122 was admitted to the facility on [DATE] with diagnosis that generalized epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body, and are sometimes accompanied by loss of consciousness) and epileptic syndromes (a set of signs and symptoms that define a type of epilepsy), lack of coordination, dysphagia (difficult swallowing), and difficulty in walking. During a review of Resident 122's History and Physical, dated 10/28/2024, indicated Resident 122 could make needs know but could not make medical decisions. During a review of Resident 122's Inventory of Resident's Personal Belongings, dated 10/28/2024, indicated Resident 122 did not have a back brace in the belonging list. During a review of Resident 122's Minimum Data Sets (MDS - a resident assessment tool), dated 10/30/2024, indicated Resident 122's cognition (ability to think, remember, and reason with no difficulty) was severely impaired, and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, and personal hygiene. During an observation on 1/7/2025 at 10:15 AM in Resident 122's room, one black back brace was hanging inside the resident ' s room with no name tag. During an interview on 1/7/2025 at 10:17 AM with Resident 122 in Resident 122's room, Resident 122 stated, the black back brace was not his belongings. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/7/2025 at 11 AM with Certified Nurse Assistant (CNA) 1 in Resident 122's room, one black back brace was hanging on a doorknob inside the resident's room. CNA 1 stated the back brace was not one of Resident 122's belongings. CNA 1 stated, she noticed the back brace had been hanging since 6:30 AM when she started her shift. CNA 1 stated, it could belong to one of the night shift staff because the company had been giving out the back brace to support the staffs that was used when lifting residents. During an interview on 1/9/2025 at 4:30 PM with the Director of Nurses (DON), the DON stated, the facility's staffs should not leave any of their belongings in any resident's room because the resident could take it and use it. The DON stated, the back brace could have bacteria that could cross contaminate bacteria and was unsanitary. During an interview on 1/10/2025 at 11 AM with the DON, the DON stated, the Social Service Director found the back brace in the Resident 122's room and could not verify to whom it belongs to. The DON stated, the back brace could be from the previous resident or from an employee. The DON stated, if the brace belonged to the previous resident, the housekeeper should have cleaned the room thoroughly and not left the brace in the room. During a review of the facility's policy and procedure (P&P) titled, Housekeeping Policy & Procedure, undated, indicated terminal cleaning of a resident room when resident is discharged included nursing will remove all linen and resident personal care items. During a review of the facility's P&P titled, Infection Prevention and Control Program, revised 10/2022, indicated facility personnel will handle, store, process, and transport linens so as to prevent the spread of infection. 42854 2. During an observation of the designated smoking area located in the facility's outdoor patio area on 1/6/2025 at 9 AM, observed signage that indicated When doing smoke breaks, kindly close the door. Leave it close until smoke break is over and make sure patio door stays closed. Thank you. Observed door open, and not entirely latched to keep door closed. The hallway where patio door was located smelled like cigarette smoke from residents' designated smoking area. During an observation of the designated smoking area from the resident hallway where patio door was located on 1/7/2025 at 1:10 PM, observed door still open and not entirely latched to keep door closed. Hallway still smelled like cigarette smoke from residents smoking in the designated smoking area. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in the designated smoking area on 1/7/2025 at 1:15 PM, activities assistant (AA) 2 was observed supervising 2 residents for smoke break. AA 2 stated she was unable to close the door completely during yesterday's smoke break as well as this morning's smoke break at 11 AM. AA 2 stated she tried to close the door best she could yesterday and this morning, but the door would not latch to close completely. AA 2 stated she did not report to maintenance or any staff that the door was not closing all the way. AA 2 stated she should have told someone so that it could be fixed. AA 2 stated usually when something is not working or broken, she would report to the maintenance staff or document in the Maintenance Repair Request Log which was located in the nursing station. AA 2 stated it was important for the door to be completely closed to ensure the cigarette smoke will not go into the facility. During a concurrent interview and observation of the patio door from resident hallway on 1/7/2025 at 1:46 PM, the Maintenance Supervisor (MS) confirmed that the door going to the designated smoking area was not able to latching and keep door closed. MS stated he was unaware of this door not working until now. MS stated when he arrives at the facility each morning, he conducts maintenance room rounds and checks the Maintenance Repair Request Logs in nursing stations. MS stated he would fix what staff tell him. MS stated if he observes that something was not working, he will fix it. MS stated checking the facility doors was not part of maintenance rounds. MS stated he did not have a log for maintenance rounds. MS stated at the moment the patio door does not lock from the inside or the outside. MS could not recall how long the patio door was not locked. During a tour of designated smoking area and maintenance area on 1/7/2025 at 1:50 PM, observed a fence separated the designated smoking area and maintenance area. Observed a latch on the fence door has no lock. In the Maintenance area was a parking lot for maintenance staff and a driveway that lead to facility's main parking lot. No gates observed, driveway open and easily accessible to the public. MS stated the fence that separates the designated smoking area and maintenance area was never locked. MS stated in the event the fire department wants to get into the facility, they do not lock the fence. During a concurrent interview and record review of the facility's Maintenance Repair Request Logs for 1/2025 from Nursing Stations 1 and 2 on 1/7/2025 at 1:24 PM, MS confirmed there was no request to fix patio door. MS stated he will fix the door now. MS stated he did not have any other log for routine inspections, he would fix things based on his visual observations and what was reported in the Maintenance Repair Request Log, nothing else. During an interview with the Administrator (ADM) on 1/7/2024 at 4:20 PM, the ADM stated the Registered Nurse Supervisor (RNS) and receptionist locks the facility doors after visiting hours which was 8 PM. ADM stated he trusts his staff and knows that the doors are always locked. The ADM stated they could use a log to make sure the doors are functional and locked, but don't have log currently. The ADM stated he will follow up with MS regarding the patio door and will have a correction tomorrow. During a concurrent interview and observation of patio door with MS and ADM on 1/8/2025 at 9 AM, observed patio door function and able to latch and close completely. MS stated the latch was fixed yesterday and the door is now able to be kept closed. MS stated the door closer located at the top of the door was also fixed to be able to lock the door from outside so that no one can enter facility. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation of fence door with MS and ADM on 1/8/2025 at 9:03 AM, observed a black pad lock on latch. MS stated there are only 2 people has key access to open fence door pad lock. MS stated only himself and his assistant have key and will lock the fence door pad lock after their shift. ADM stated the fence door will remain locked for residents' safety. During an interview with the Director of Nursing (DON) on 1/10/2025 at 11:08 AM, the DON stated the doors in the facility should remained closed and locked to ensure no one comes in the facility. The DON stated the function of the patio door should have been reported and that anyone could have reported it was broken. During a review of the facility's policy & procedure (P&P) titled Safety, Resident revised on 9/2019 indicated the facility would create a safe environment for the resident. The P&P indicated to report all faulty equipment immediately and do not use. During a review of the facility's P&P titled Physical Environment revised on 5/2022 indicated the facility would establish procedures for routine and non-routine care equipment and to ensure that it remains in good working order for resident and staff safety. The P&P indicated routine inspections, and maintenance will be recorded in the Preventive Maintenance Log.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review the facility failed to implement their smoking policy and procedure for one of three sampled residents (Resident 97) by failing to provide a smoke free environment as indicated in the facilities policy. This deficient practice had the potential to place Resident 97 at risk associated with inhaling secondhand smoke that can potentially lead to diseases such as lung cancer, stroke, heart disease and death. Findings: During a review of Resident 97's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated admission to the facility on [DATE] with diagnoses that included stress fracture (a small crack in a bine caused by repetitive force or over use) of the left femur (left thigh bone), morbid obesity due to excess calories (a condition of having to much body fat) . During a review of Resident 97's History and Physical (H&P) dated 11/23/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 97's Minimum Data Set (MDS - a resident assessment tool), dated 10/22/2024, indicated the resident cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. During a review of facility provided document titled Grievance Resolution Form dated 11/20/2024 timed at 2:15 PM, indicated a grievance received by Resident 97 to Activities Assistant 1 (AA1). The grievance indicated Resident 97 reported smelling smoke from resident smoking outside at smoking patio. Furthermore, the form indicated steps taken to investigate grievance included: SSA assistant offered room change, sign put in place to close door when smoking. During an interview on 1/06/2025 at 9:35 AM with Resident 97, Resident 97 stated she had filed a grievance with the facility regarding the strong smell cigarette of smoke that she can smell all day, but it gets especially worst during smoke break. Resident 97 stated the facility offered to switch her room, but she has had many rooms changes in the past and did not want to move again. Resident 97 stated the SSA 1 had told her she would put a sign by the door to keep the door closed and would tell all the staff but despite of that the smell continued to come into her room everyday just as strong if not even stronger. During an observation on 1/06/2025 at 1:15 PM of patio exit doorway directly across Resident 97's room, there was a sign observed next to the exit doorway indicating When doing smoke breaks, kindly close the door (For Resident 97 ' s room). Leave it closed until smoke break is over and make sure patio door stays closed. The door was observed cracked open while Residents were observed outside smoking during their smoke break. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 1/07/2025 at 1:16 PM with Certified Nursing Assistant (CNA)3, CNA 3 stated she could smell smoke in the hallway in front of Resident 97's room. CNA 3 stated the cigarette smoke smell was coming in from the outside because there were Residents outside in the patio currently on smoke break and the door was cracked opened. During a concurrent observation and interview on 1/07/2024 at 1:20 PM with Maintenance Assistant (MA)2 of Patio door across resident 97's room that leads to smoking Patio. MA2 stated door was opened because the latch that keeps the door closed was broken preventing the door from closing. MA 2 stated he was not aware the door latch was broken and would not close and did not know how long it had been broken as it was not reported to the maintenance department. During an interview on 1/10/2025 at 10:51 AM with Director of Nursing (DON), DON stated some of the complications that can be caused by secondhand smoke could be cancer or other health conditions for some people. DON stated the facility had implemented steps such as posting the signage on the door across from Resident 97's door to remind everyone to keep the door closed during smoke breaks to prevent cigarette smoke from entering the facility and going into Resident 97's room but was not aware the door latch was not working until 1/7/2025. During a review of the facility's policy and procedure (P&P) titled Smoking Policy dated with a revised date of 12/2016 indicated It is the facility policy to provide to it's residents a smoke free environment .