STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 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 48678

Based on observation, interview, and record review, the facility failed to ensure two (2) of 2 sampled residents (Residents 222 and 11) were treated with respect and dignity in accordance with the facility policy by failing to ensure:

1. Resident 222 had a dignity bag (urine drainage bag holder to prevent public view) over the resident's indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine).

2.Resident 11 did not have any food crumbs (small pieces of food that have broken off from a larger piece) on the resident's shirt on 12/16/2024.

These deficient practices have the potential to negatively affect Residents 222 and 11's self-worth, self-esteem, and psychosocial well-being.

Findings:

1. During a review of Resident 222's Admission Record, the Admission Record indicated Resident 222 was admitted to the facility on [DATE] with diagnosis of pneumonia (an infection that affects one or both lungs and causes them to fill up with fluid or pus), chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems), and neurogenic bladder (a lack of bladder control due to a brain, spinal cord, or nerve problem).

During a review of Resident 222's History and Physical, dated 12/5/2024, the H&P indicated Resident 222 had the capacity to understand and make decisions.

During a review of Resident 222's Order Summary, dated 12/6/2024, the Order Summary indicated an indwelling catheter was to be placed to prevent movement and urethral traction (a medical procedure where a catheter is inserted into the urethra and then gently pulled on to apply pressure on the bladder neck) for neurogenic bladder, and to change urinary drainage bag as needed.

During an interview on 12/16/2024 at 10:09 AM with Resident 222, in Resident 222's room, Resident 222 stated seeing the drains from his body such as his feeding tube, and seeing his urine made him feel weak. Resident 222 stated he would prefer not to see his drains.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Californian Pasadena Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 Bellefontaine Street Pasadena, CA 91105	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/16/2024 at 10:11 AM with Certified Nursing Assistant 4 (CNA 4), in Resident 222's room, CNA 4 stated Resident 222 had a full bag of urine in his catheter bag and needed to be drained. CNA 4 stated the catheter bag did not have a dignity bag to cover the yellow urine to prevent Resident 222 and others from seeing it. CNA 4 stated it was important to use a dignity bag to cover the sight of urine to promote respect and dignity for residents, and to follow facility policy. During an interview on 12/18/2024 at 9:05 AM with the Director of Nursing (DON), the DON stated the facility's policy regarding dignity bags was to keep urinary catheter bags covered to promote dignity for residents, since urine is a waste product from the human body, and it is not pleasant to see. 50958 2. During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted on [DATE] with diagnoses including cerebrovascular disease (a condition that affects blood flow to the brain), dysphagia (difficulty swallowing), muscle weakness, Parkinson's disease(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movements), type 2 diabetes (a disorder characterized by difficulty in blood sugar control), anxiety disorder (a mental health condition that causes excessive and uncontrollable feelings of fear and anxiety), quadriplegia (paralysis from the neck down, including legs and arms), abnormalities of gait and mobility, and chronic kidney disease. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 10/18/2024, the MDS indicated Resident 11 had intact cognitive (ability to remember things, solve problems, or make decisions) skills for daily decision making. The MDS indicated Resident 11 needed supervision or touching assistance (a helper provides verbal sues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating. Resident 11 required partial assistance (help less than half the effort) with oral hygiene and maximal assistance (help more than half the effort) with upper body dressing and personal hygiene. During a review of Resident 11's Care Plan, initiated on 7/19/2024, the Care Plan indicated Resident 11 had limited physical mobility related to Parkinson's disease. The Care Plan indicated the facility needs to provide supervision assistance for Resident 11 during eating. During a concurrent observation and interview on 12/16/2024 at 12:43 PM in the dining room, Resident 11 was using her dominant (right) hand, which was trembling when observed scooping her food with a spoon. Resident 11 had clumps of cherry pie on her chest and on the table. There was no staff assisting Resident 11 with eating. Resident 11 stated she needed a little help with eating the cherry pie. During a concurrent observation and interview on 12/16/2024 at 12:55 PM with Restorative Nursing Assistant 1 (RNA 1) in the dining room, RNA 1 stated that Resident 11 had difficulty to hold the spoon, scoop the food out of the plate, and need help with eating. RNA 1 stated the facility should provide assistance to Resident 11 with eating. Resident 11 was observed with food crumbs on her shirt, by the chest area. RNA 1 stated food crumbs left on Resident 11's clothes will make her feel lose her dignity and could discourage Resident 11 from eating. (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 review of the facility's policy titled, Dignity, dated February 2021, the policy indicated demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents, for example help the resident to keep urinary catheter bags covered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to accommodate the needs for two of 14 sampled residents (Residents 222 and 126) by failing to ensure the resident's call light (device used by residents to call staff) was within the resident's reach. This deficient practice had the potential for delayed provision of care to Residents 222 and 126, which could negatively affect the residents' overall wellbeing. Findings: 1. During a review of Resident 222's Admission Record, dated 12/18/2024, the Admission Record indicated Resident 222 was admitted to the facility on [DATE] with diagnosis of pneumonia (an infection that affects one or both lungs and causes them to fill up with fluid or pus), chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems), and neurogenic bladder (a lack of bladder control due to a brain, spinal cord, or nerve problem). During a review of Resident 222's History and Physical, dated 12/5/2024, the H&P indicated Resident 222 had the capacity to understand and make decisions. During a concurrent observation and interview on 12/16/2024 at 10:09 AM with Resident 222 in the resident's room, Resident 222 was trying to position his pillow behind his head with his left arm but was struggling to get the pillow in place. Resident 222 stated he was trying to reach for his call light but could not reach it. During a concurrent observation and interview on 12/16/2024 at 10:11 AM with Certified Nursing Assistant 4 (CNA 4), in Resident 222's room, CNA 4 stated Resident 222's call light was on the floor and should have been on the bed, and in a position/ location where Resident 222 could reach it. CNA 4 stated it is important to keep residents' call lights within their reach so that they can call for the facility staff and ask for the help they need. The CAN 4 verified Resident 222 was unable to reach for his call light cord because it was on the floor. During an interview on 12/18/2024 at 9:16 AM with the Director of Nursing (DON), the DON stated, call lights should be within the resident's reach, and call lights on the floor are not an acceptable practice because it is important that residents can reach their call light to ask staff for assistance to meet resident's needs. 50958 2. During a review of Resident 126's Admission Record, the Admission Record indicated that Resident 126 was admitted on [DATE] with diagnoses including metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood), hypertensive (high blood pressure) heart disease, atrial fibrillation (an irregular and often very rapid heart rhythm), chronic kidney disease (a progressive damage and loss of function in the kidneys). (continued on next page)

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	055480	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 126's History and Physical (H&P), dated 12/16/2024, the H&P indicated Resident 126 had the capacity to understand and make decisions. During a review of Resident 126's Care Plan, revised 12/16/2024, the Care Plan indicated Resident 126 has Activities of Daily Living (ADL) self-care and/or mobility performance deficit and needs the call light within reach to meet the resident's needs. During a concurrent observation and interview on 12/16/2024 at 10:39 AM with Resident 126 in his room, Resident 126 was lying in bed on his back with the head of bed elevated. Resident 126's call light was not on his bed. Resident 126 stated he cannot reach the call light. During a concurrent observation and interview on 12/16/2024 at 10:45 AM with Certified Nursing Assistant 1 (CNA1) in Resident 126's room, Resident 126's call light was under the bed. CNA 1 stated the call light was underneath Resident 126's bed and was not within Resident 126's reach. CNA 1 stated the facility should place the call light within resident's reach to ensure staff is able to provide resident's needs especially during emergencies. During an interview on 12/19/2024 at 9:40 AM with DON, the DON stated it was important to ensure the call light is within the resident's reach so the resident can get assistance on time to meet their needs. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, revised 03/2021, the P&P indicated the facility should ensure the remote control or task lighting are easily accessible. During a review of the facility's P&P titled, Answering the Call Light, revised 3/2022, the P&P indicated the facility should ensure that the call light is within reach and accessible to the resident all times.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50958 Based on interview and record review, the facility failed to ensure two of two residents (Resident 70 and Resident 71) reviewed for closed records had a discharge care plan. This failure had the potential to result in Resident 70 and Resident 71 increasing their risk of preventable readmissions due to not focusing on their discharge plan and goals, not actively preparing and effectively transitioning to post discharge care. Findings: 1. During a review of Resident 70's Admission Record, the Admission Record indicated that the facility admitted Resident 70 on 8/22/2024 with diagnoses including type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control), muscle weakness, abnormalities of gait and mobility, depression, hypertensive (high blood pressure) heart disease, atrial fibrillation (an irregular and often very rapid heart rhythm), congestive heart failure (a heart disorder causes the heart to not pump the blood efficiently), dysphagia (difficulty swallowing), and cognitive communication deficit. During a review of Resident 70's Minimum Data Set (MDS- a resident assessment tool), dated 8/29/2024, the MDS indicated Resident 70 had moderately impaired cognitive (ability to remember things, solve problems, or make decisions) skills for daily decision making. The MDS indicated Resident 70 required partial physical assistance from staff to complete activities of daily living. During a review of Resident 70's Physician Order dated 10/19/2024, the Physician Order indicated Resident 70 could be discharge home on 10/21/2024 under home health for physical therapy, occupational therapy, and nursing. 2. During a review of Resident 71's Admission Record, the Admission Record indicated that the facility admitted Resident 71 on 8/29/2024 with diagnoses including fracture of lower end of left ulna and radius (broken bone above the wrist on left hand), muscle weakness, abnormalities of gait and mobility, cognitive communication deficit, anemia (the body does not have enough healthy red blood cells), dementia (a progress state of decline in mental abilities), disorders of right acoustic [NAME] (could cause the hearing and balance problem), osteoporosis (weak and brittle bones due to lack of calcium and vitamin D), dysphagia, and history of falling. During a review of Resident 71's MDS dated [DATE], the MDS indicated Resident 71 had moderately impaired cognitive skills for daily decision making and required assistance from staff to complete activities of daily living. During a review of Resident 71's Physician Order dated 9/20/2024, the Physician Order indicated Resident 71 was to be discharged home on 9/24/2024 with home health for physical therapy, occupational therapy, nursing (registered nurse), and home health aide. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/18/2024 at 10:28 AM with the Social Service Director (SSD), Resident 70's care plan, revised on 11/19/2024 and Resident 71's care plan, revised on 10/17/2024 were reviewed. There was no discharge care plan for Resident 70 and Resident 71. The SSD stated she was responsible for developing the discharge care plan and she had not made a discharge care plan for Resident 70 and Resident 71. The SSD stated she should develop a care plan of discharge, so the resident would know their goals and meet their needs after discharge. During an interview on 12/19/2024 at 9:40 AM with the Director of Nursing (DON), the DON stated it was important to have care plans for discharge, so the facility can let the resident know the goals for discharge and help the resident meet their needs to avoid preventable readmission. During a review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan, revised 12/2016, the P&P indicated, Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan. and The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge.

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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 0689

Level of Harm - Actual harm

Residents Affected - Few

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 48903

Based on interview and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 3) who was assessed at risk for falls and with diagnoses of dementia (a progressive state of decline in mental abilities) was free from falls and injury in accordance with the resident's care plan for At risk for fall and Occupational Therapist (OT; a healthcare provider who helps you improve your ability to perform daily tasks like getting dressed or using a computer) Evaluation & Plan of Treatment (OTEPT) to provide maximal assistance (helper does more than half the effort) to the resident when showering/bathing. On 12/3/2024, in the facility's shower room, Certified Nurse Assistant (CNA) 3 turned away from Resident 3 to grab the chucks (under pad - a kind of ultra-absorbent incontinence [lack of voluntary control over urination or defecation] products that are designed to be placed on the top of a bed, wheelchair, or any surface you want to protect) and clean towel leaving the resident unattended while in the shower chair.

This deficient practice resulted in Resident 3 leaning forward and falling in the shower room on 12/3/2024 around 10:40 AM. Resident 3 fell backwards in a supine (facing up) position where the resident struck her head during the fall. Resident 3 experienced pain to her head (specific location not specified). The paramedics (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) came to pick up the resident and identified a hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel) on the back of Resident 3's head. Resident 3 was sent to General Acute Care Hospital (GACH) by the paramedics on 12/3/2024 (time unknown) where the resident was found to have an acute (sudden) anterior (front) left second through sixth rib (slender curve bones protecting the lungs) fractures (a break in a bone) and was admitted to the GACH's Intensive Care Unit (ICU; a specialized hospital ward that provides intensive medical care to critically ill or injured patients who require close monitoring and life-support measures).

Findings:

During a review of Resident 3's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM; a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia, schizophrenia (a mental illness that is characterized by disturbances in thought) and history of falling.

During a review of Resident 3's Admission Fall Risk Assessment (AFRA), dated 11/26/2024, AFRA indicated Resident 3 was a fall risk.

During a review of Resident 3's Care Plan (CP), dated 11/26/2024, the CP indicated Resident 3 was at risk for falls related to history of multiple falls prior to admission, seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), history of loss of consciousness and wheelchair bound with unsteady transfer. The CP indicated the CP goal was resident will have no injuries related to falls and interventions included:

1. Assess and anticipate resident's needs: body positioning.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	2. Keep environment free of clutter and safety hazards. 3. Refer to rehabilitation (health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired) for evaluation and treatment as indicated. During a review of Resident 3's Psychologist Intake Note (PIN), dated 11/28/2024, the PIN indicated Resident 3 had poor insight, poor judgement/impulse control and functional status was severely impaired. During a review of Resident 3's History and Physical (H&P), dated 12/2/2024, the H&P indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 12/3/2024, the MDS indicated the resident was assessed to have moderately impaired cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required maximal assistance for showering/bathing. The MDS also indicated Resident 3 was assessed to require moderate assistance (helper does less than half the effort) for toileting, upper/lower body dressing and taking on/off footwear. In addition, the MDS indicated Resident 3 had a fall in the last month prior to admission. During a review of Resident 3's Paramedic Report (PR), dated 12/3/2024, the PR indicated: 1. Resident 3 was found to have a hematoma to the posterior (back) left side of the resident's head. 2. Staff (unspecified) reported Resident 3 fell backwards while taking a shower, hitting the back of the resident's head on the floor. 3. Staff (unspecified) reported Resident 3 loss consciousness for about five (5) seconds. 4. Resident 3 was taken to GACH. During a review of Resident 3's GACH Trauma Surgery History and Physical (TSHP), dated 12/3/2024 entered at 12:33 PM, the TSHP indicated Resident 3 sustained a ground level fall in the shower, complained of head pain and had a scalp (skin covering the head) hematoma. TSHP indicated a Computed Tomography (CT; a computerized x-ray [a quick, painless test that captures images of the structures inside the body] imaging procedure) of Resident 3's chest, abdomen, and pelvis (the bones between the lower abdomen and upper thighs that connect the spine to the legs) were performed with findings of acute anterior left second through sixth rib fractures. TSHP indicated Resident 3 was admitted to the GACH's ICU. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 3's Interdisciplinary Team Progress Note (IDT), dated 12/3/2024 entered at 4:55 PM, the IDT indicated Resident 3 had a witnessed fall on 12/3/2024 at around 10:40 AM in the facility's shower room. IDT indicated Resident 3 was seated in a shower chair while being assisted by CNA 3 and Certified Nursing Assistant Student (Student 1). IDT indicated CNA 3 turned to grab a clean towel but Resident 3 leaned forward causing the shower chair to flip. IDT indicated Resident 3 fell backwards in a supine position and struck the residents head (not specified where the resident hit her head) during the fall. IDT indicated Resident 3 was assessed by staff but later in the resident's room, the resident complained of pain to her head. IDT indicated paramedics came to pick up the resident to transfer to GACH and the paramedics identified a hematoma on the back of Resident 3's head. During an interview on 12/17/2024 at 1:06 PM, CNA 3 stated, on 12/3/2024, CNA 3 was with Resident 3 in the shower room. Resident 3 was sitting in the shower chair while Student 1 was at the right side of the resident buttoning Resident 3 's gown. CNA 3 stated Student 1 was using both of her hands while buttoning Resident 3's gown when Resident 3 fell . CNA 3 stated she was behind Resident 3 and turned around to put a chuck and clean towel on the resident's wheelchair to prepare transferring Resident 3. CNA 3 stated while she was turned facing away from Resident 3, she suddenly heard a loud noise, a sound that something fell , she turned around and saw Resident 3 on the floor on her left side with the resident's chest area and stomach on the floor. CNA 3 stated she did not actually see Resident 3 falling as she (CNA 3) was not facing the resident and was fixing the chuck and clean towel in the wheelchair. CNA 3 stated, to prevent Resident 3 from falling, Resident 3 should not be left unattended. CNA 3 stated, Resident 3 cannot sit on her own that was why CNA 3 always need someone to be with her when showering Resident 3. CNA 3 stated she did not try to find another CNA to assist her on 12/3/2024 to provide shower to Resident 3 since she had Student 1 with her but should have looked for another CNA to assist. During a concurrent interview and record review with Physical Therapist (PT, a healthcare provider who helps you improve how your body performs physical movements) 1 on 12/17/2024 at 2:12 PM, Resident 3's PT Evaluation & Plan of Treatment (PTEPT) dated 11/27/2024 was reviewed. The PTEPT indicated: 1. Resident 3 had a history of fall. 2. Resident 3 required maximal assistance to stand from sitting. 3. Resident 3 required maximal assistance to transfer from chair to chair. 4. Resident 3 had impaired strength to both lower extremities (legs). PT 1 stated, Resident 3 had a fall at home due to possible seizure. She overestimated her abilities. She could not get on the wheelchair by herself. Her mind would stray to random incidents or topics. PT 1 also stated it would not be safe to take your eyes off and hands off Resident 3 when taking a shower since the resident was assessed to need maximal assistance during shower. During a concurrent interview and record review with OT 1 on 12/17/2024 at 2:17 PM, Resident 3's OTEPT dated 11/27/2024 was reviewed. OTEPT indicated: 1. Resident 3 was a fall risk, had dementia and was hard of hearing. (continued on next page)

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	055480	A. Building B. Wing	12/19/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Resident 3 required maximal assistance for showering/bathing. OT 1 stated, She (Resident 3) was maximum assist for showers. That would require one helper. They would do the scrubbing, rinsing, drying. She required a shower chair. She required touching assistance for safety. OT 1 stated it would not be safe to leave Resident 3 unassisted or take your eyes off and hands off Resident 3 during a shower or after shower. During an interview on 12/17/2024 at 3:20 PM with Student 1, Student 1 stated on 12/3/2024 between 10:30 AM to 11 AM, Student 1 was shadowing (observing) CNA 3 and have just completed assisting CNA 3 showering Resident 3. Student 1 stated she was at the right side of Resident 3, there was a low divider between her and the resident, while assisting CNA 3 to shower Resident 3. Student 1 stated Resident 3 was facing the wall where the shower head is, while the resident was sitting on the shower chair. Student 1 stated CNA 3 handed her Resident 3's gown and Student 1 was buttoning Resident 3's gown using both of her hands when Resident 3 leaned forward and fell . Student 1 stated it happened so fast that she did not get a chance to go around the divider to catch Resident 3 from falling. Student 1 stated CNA 3 was behind Resident 3, and CNA 3 was not facing Resident 3 because CNA 3 was putting the chuck and clean towel on the wheelchair to prepare to transfer the resident. Student 1 stated Resident 3 landed on her back and/or on the left side. Student 1 stated she did not see Resident 3 hit her head but Resident 3 was complaining of pain on the head after the fall. Student 1 stated CNA 3 did not tell her that Resident 3 was a risk for fall. During a concurrent interview and record review on 12/18/2024 at 11:58 AM with the Director of Nursing (DON), Online Nurse Assistant Training Program Clinical Training Site Agreement (Training Agreement - contract between the Student 1's school and the facility indicating the terms and limitations of CNA students with regards to resident's care) dated 2/2022 was reviewed. The Training Agreement form indicated facility staff may not be used to proctor, shadow, or teach the training program students. The DON stated, the contract indicated, the nursing student including Student 1 should not be doing the CNA's work, or doings hands on care to the residents without the presence of the school's instructor. The DON also stated CNA 3 should not have relied on the help of Student 1 when showering residents. During a concurrent interview and record review on 12/18/2024 at 12:05 PM with the DON, the facility's policy, and procedure (P&P) titled, Fall and Fall Risk Managing dated 3/2018 was reviewed. The P&P indicated: 1. Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 2. Environmental factors that contribute to the risk of falls include wet floors. 3. Resident conditions that may contribute to the risk of falls include delirium and other cognitive impairment, lower extremity weakness, balance, and gait (a person's manner of walking) disorders and incontinence. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON stated, the policy indicated, fall risk factors include wet floors, delirium and other cognitive impairment, lower extremity weakness, incontinence, and balance and gait disorders. The DON stated, Resident 3 was in the shower room where the floor was wet, and the resident has dementia, incontinence, balance and gait problems and lower extremity weakness. The DON also stated, all these factors increase the Resident 3 risk for falls and the CNA should not have turned away from the resident to get chucks and clean towel. The DON stated Reisdent 3's fall could have been prevented if CNA 3 did not leave the resident unattended/ turned away from the resident to get chucks and clean towel on 12/3/2024.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 54), had the head of bed (HOB) elevated at minimum 30 degrees during tube feeding infusion in accordance with the facility policy. This deficient practice had the potential for Resident 54 aspirating (feeding could enter the windpipe and lungs) and result in complications such as aspiration pneumonia (an inflammation of the lungs and bronchial tubes that occurs after foreign matter was inhaled), hospitalization , and death. Findings: During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was admitted on [DATE] with diagnosis of dysphagia (difficulty or discomfort in swallowing) and a gastrostomy tube (G-tube, tube inserted through the belly that brings nutrition directly to the stomach). During a review of Resident 54's History and Physical (H&P, a term used to describe a physician's examination of a resident), dated 11/8/2024, the H&P indicated Resident 54 does not have the capacity to understand and make decision. During a review of Resident 54's MDS, the MDS indicated Resident 54 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for oral hygiene, toileting, showering, upper and lower body dressing, personal hygiene, rolling left and right, sit to lying, and laying to sitting on side of bed. The MDS indicated Resident 54 had a feeding tube while not a resident of the facility and within the last seven days. During a review of Resident 54's Order Summary, dated 11/6/2024, the Order Summary indicated elevate head of bed 30 to 45 degrees during enteral feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) and one hour after enteral feeding. During a concurrent observation and interview on 12/16/2024 at 2:27 PM with Licensed Vocational Nurse 4 (LVN 4) in Resident 54's room, Resident 54's tube feeding was observed to be infusing. LVN 4 stated, Resident's (Resident 54) head of bed seemed to be elevated at 20 degrees, but definitely not at the minimum 30 degrees as ordered by physician. The LVN 4 stated Resident 54 was at risk for aspiration, especially because Resident 54 required assistance from staff to turn. During an interview on 12/18/2024 at 9:26 AM with the Director of Nursing (DON), the DON stated it is important to follow physician's orders to elevate the HOB during tube feedings to prevent aspiration, and the best practice for positioning a resident receiving a feeding infusion is about 40 to 45 degrees of head elevation. During a review of the facility's policy titled, Enteral Feedings- Safety Precautions, dated 11/2024, the policy indicated to elevate the head of the bed at least 30 degrees during tube feeding and at least one hour after feeding.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50958 Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 122 and Resident 22) on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) treatment received communication records from the hemodialysis center when the residents returned to the facility. This failure had the potential to result in Resident 122 and Resident 22's health status not being communicated in a timely manner and not receiving appropriate post dialysis care. Findings: 1. During a review of Resident 122's Admission Record, the Admission Record indicated the facility admitted Resident 122 on 12/3/2024 with diagnoses including chronic kidney disease (a progressive damage and loss of function in the kidneys), hyperkalemia (high potassium levels in blood), thrombocytopenia (low platelet count in blood), hypo-osmolality (levels of electrolytes, proteins, and nutrients in the blood are lower than normal), hyponatremia (low sodium levels in blood), end stage renal disease (ESRD-irreversible kidney failure), and dependence on renal (kidney) dialysis. During a review of Resident 122's History and Physical (H&P, the initial clinical evaluation and examination of the resident), dated 12/4/2024, the H&P indicated, Resident 122 had the capacity to understand and make decisions. During a review of Resident 122's Minimum Data Set (MDS- a resident assessment tool), dated 12/7/2024, the MDS indicated Resident 122 had moderately impaired cognitive (ability to remember things, solve problems, or make decisions) skills for daily decision making. During a concurrent interview and record review on 12/17/2024 at 9:42 AM with the Director of Nursing (DON), Resident 122's Physician Order, dated 12/16/2024 was reviewed. The Physician Order indicated that Resident need to attend dialysis on Mondays, Wednesdays, and Fridays. The DON stated Resident 122 needed to go to dialysis on Mondays, Wednesdays, and Fridays which were 12/4/2024, 12/6/2024, 12/9/2024, 12/11/2024, 12/13/2024, and 12/16/2024. During a concurrent interview and record review on 12/17/2024 at 9:40 AM with the DON, Resident 122's Communication Record for Dialysis Residents (CRDR) were reviewed. The CRDR indicated there were no CRDR forms for dates 12/4/2024, 12/6/2024, 12/9/2024, 12/11/2024, and 12/16/2024. The DON stated there was no documentation in the CRDR indicating Resident 122 received the dialysis on 12/4/2024, 12/6/2024, 12/9/2024, 12/11/2024, and 12/16/2024. 2. During a review of Resident 22's Admission Record, the Admission Record indicated the facility admitted Resident 22 on 12/21/2021 with diagnoses including dependence on renal dialysis, chronic kidney disease, hyperosmolality and hypernatremia (high amount sodium in the blood). During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22 had moderately impaired cognitive skills for daily decision making. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/18/2024 at 11:40 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 22's CRDR and Resident 22's Physician order, dated 12/29/2023 were reviewed. The CRDR indicated there were no CRDR forms for dates 11/6/2024 and 11/13/2024. The Physician order indicated Resident 22 needed to go to dialysis every Mondays, Wednesdays, and Fridays. LVN 2 stated there was no documentation in the CRDR indicating Resident 22 went to dialysis on 11/6/2024 and 11/13/2024, which were Wednesdays. LVN 2 stated resident should have the CRDR for every time when resident went to dialysis to communicate resident's condition and monitor side effects and complication from dialysis. During an interview on 12/19/2024 at 9:40 AM with the DON, the DON stated it was important to have communication forms for dialysis, in order for the facility staff to check and record any new orders, new medication, document post dialysis vital signs, and complications post dialysis. During a review of the facility's policy and procedure (P&P) titled, Long Term Care Facility Outpatient Dialysis Services Coordination Agreement, dated 12/2024, the P&P indicated the facility should ensure that there was documented evidence of collaboration of care and communication between the facility and the ESRD Dialysis Unit and maintain a copy. During a review of the facility's P&P titled, Hemodialysis Access Care, revised 9/2010, the P&P indicated the facility nurse should document any part of report from dialysis nurse after dialysis being given.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to ensure one of 14 sampled residents (Resident 34), received Apixaban (medication to prevent blood clots) as indicated on the physician's order. This deficient practice had the potential to cause Resident 34 serious problems such as heart attack (a condition when blood flow to the heart muscle is suddenly blocked), deep vein thrombosis (DVT- a condition where a blood clot forms in a deep vein, usually in the legs, leading to serious complications), pulmonary embolism (a condition where a blood clot travels to and blocks an artery in the lungs), and stroke. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was admitted to the facility on [DATE] with diagnosis of atrial fibrillation (A-fib, an abnormal heart rhythm characterized by rapid and irregular beating) and history of myocardial infarction (MI-a condition when blood flow to the heart muscle is suddenly blocked). During a review of Resident 34's History and Physical (H&P- a term used to describe a physician's examination of a resident), dated 9/11/2024, the H&P indicated Resident 34 had the capacity to understand and make decisions. During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool), dated 9/17/2024, the MDS indicated Resident 34 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 34 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for lower body dressing. The MDS indicated Resident 34 had an active diagnosis of atrial fibrillation or other dysrhythmias (irregular heartbeats), heart failure (a condition that occurs when the heart can't pump enough blood and oxygen to the body's organs), coronary artery disease (a condition where the arteries that supply blood to the heart muscle become narrowed or blocked), and hypertension (chronic changes in the left heart ventricle and atrium, and coronary arteries as a result of chronic raised blood pressure). The MDS indicated Resident 34 was taking and required use of an anticoagulant (medication used to decrease the body's ability to form blood clots). During a review of Resident 34's Order Summary, dated 10/8/2024, the Order Summary indicated give Apixaban five (5) milligram (mg- metric unit of measurement, used for medication dosage and/or amount) one tablet by mouth every 12 hours for A-fib blood clot prevention. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/2024 at 12:01 PM with Resident 34, in Resident 34's room, Resident 34 stated, she did not receive her Apixaban medication last week because the facility did not have it in stock. Resident 34 stated she was very concerned about not getting her medication because she had A-fib and needs to take it every day to treat her heart medical conditions. Resident 34 stated she had spoken to the Administrator verbalizing her concerns. During a concurrent interview and record review on 12/17/2024 at 4:11 PM with Licensed Vocational Nurse 3 (LVN 3), of Resident 34's Medical Administration Record (MAR), LVN 3 stated that on 12/6/2024, 12/7/2024, 12/8/2024, 12/9/2024, and 12/10/2024, Resident 34 did not receive her Apixaban medication due to awaiting delivery from pharmacy. LVN 3 stated there was no documentation indicating the facility physician was notified regarding the lack of Apixaban. LVN 3 stated Resident 34 was at high risk for developing blood clots, heart attack, pulmonary embolism, and DVT due to her A-fib and heart conditions, and not taking Apixaban increased the risk of Resident 34 to develop blood clots. LVN 3 stated the licensed nurses should have notified the physician immediately to find an alternate medication for Resident 34. During an interview on 12/17/2024 at 4:31 PM with the Director of Nursing (DON), the DON verified that Resident 34 did not receive Apixaban on the mentioned 5 days. The DON stated the licensed nurses should have notified the physician immediately to find an alternative medication to treat Resident 34's diagnosis since omitting Apixaban could result in Resident 34 getting a heart attack, MI, and stroke. The DON stated it is important that residents receive their prescribed medication to keep them in stable condition, and this incident should have been prevented by ensuring Apixaban was in stock at the facility at all times. During a review of the facility's policy titled, Pharmacy Services, dated 4/2022, the policy indicated residents have sufficient supply of their prescribed medications and receive medications in a timely manner. In collaboration with the dispensing pharmacy and the facility, the consulting pharmacist oversees the development of procedures for acquisition and availability of medications. The policy indicated pharmaceutical services consist of the process of identifying, evaluating, and addressing medication-related issues including the prevention and reporting of medication errors. During a review of the facility's policy titled, Administering Medications, dated 4/2019, the policy indicated medication errors are documented, reported, and reviewed by the facility staff to inform process changes and or the need for additional staff training.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on interview and record review the facility failed to ensure the physician addressed the medication regimen review (MRR/Drug Regimen Review - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) on 6/10/2024 to consider a gradual dose reduction (GDR - a periodic attempt to manage a resident's behavioral issues with a lower dose of medication) related to the use of Seroquel (a medication used to treat psychosis) or document a clinical rationale as to why an attempt would be contraindicated for one of five sampled residents (Resident 52). The deficient practice increased the risk for Resident 52 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to Seroquel therapy possibly leading to impairment or decline in the resident's mental, physical, and /or psychosocial status. Findings: During a review of Resident 52's Admission Record (a document containing diagnostic and demographic information), dated 12/18/0224, the Admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and psychosis (a mental disorder characterized by a disconnection from reality). During a review of Resident 52's Minimum Data Set (MDS- a standardized resident assessment tool), dated 11/8/2024, the MDS indicated Resident 52 was taking an antipsychotic in the last seven days or since admission on a routine basis, and a GDR had not been attempted, and a GDR had not been documented by a physician as clinically contraindicated. The MDS indicated Resident 52 did not have any potential indicators of psychosis. Resident 52 did not have mood or behavioral symptoms. The MDS indicated Resident 52 had severe cognitive skills (a condition that makes it difficult for a person to remember, learn, concentrate, or make decisions that affect their daily life) for daily decision making. The MDS indicated Resident 52 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) from staff for upper and lower body dressing, personal hygiene, putting on footwear, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and transfer from chair to bed. The MDS indicated Resident 52 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting and showering. During a review of Resident 52's Order Summary Report (a summary of all currently active physician orders), dated 3/28/2024, the Order Summary Report indicated Seroquel 25 milligrams (mg - a unit of measure for mass) by mouth at bedtime for psychosis manifested by responding to internal stimuli thinking she works in the facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the consultant pharmacist's recommendation, dated 6/10/2024, the pharmacist's recommendation indicated a note to the attending physician to consider if a dose change for Resident 52's Seroquel 25 mg was warranted at this time due to psychoactive medications must undergo a psychotropic drug regimen review with evaluation for dose reduction every six months for the first year and annually thereafter. During a review of Resident 52's clinical record, there was no documentation found indicating the physician responded to the consultant pharmacist's request to consider a GDR for Seroquel or any other indication the dose of Seroquel had changed since 3/8/2024. During a concurrent interview and record review of Resident 52's Psychotropic (relating to or denoting drugs that affect a person's mental state) Summary Sheet (a monitoring log of behavioral episodes of residents who are on psychotropic medication) on 12/17/2024 at 12:21 AM with the Assistant Director of Nursing (ADON), the ADON verified that the Psychotropic Summary Sheet indicated Resident 52 had zero episodes of psychosis for the months of March, April, May, June, July, August, and September 2024. During an interview on 12/19/2024 at 10:46 AM, with the ADON, the ADON stated the facility failed to ensure the physician responded to the consultant pharmacist's request to decrease the dose of Seroquel for Resident 52. The ADON stated there is no record of a specific response to the pharmacist's request or any other record that addresses the dosage of Seroquel specifically and the resident has been on the same dose since March of 2024. The ADON stated the physician should have responded to the pharmacist's recommendations within one to two days from the pharmacist's written report. The ADON stated the facility failed to decrease the dose or document a resident-specific reason why a dosage reduction would be contraindicated. The ADON stated the failure to consider a GDR or respond to the pharmacist's request for GDR increased the risk that Resident 52 may experience adverse effects of Seroquel, such as tardive dyskinesia (a condition affecting the nervous system, such as uncontrollable jerky movements of the face and body often caused by long-term use of some psychiatric drugs), cognitive impairment, tremors, drooling, rigidity, due to using a higher dose than necessary which could have negatively impacted her quality of life. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review, revised May 2019, the P&P indicated copies of medication regimen review reports, note to attending physicians including physician responses are maintained as part of the permanent medical record, and medication regimen reviews are done upon admission and at least monthly thereafter, or more frequently if indicated. During a review of the facility's P&P titled, Tapering Medication and Gradual Drug Dose Reduction , revised April 2024, the policy indicated, The physician will review periodically whether current medication are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or enduring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medication, or with a lower dose . The physician will order appropriate tapering of medication, as indicated . The policy indicated the staff and practitioner will consider tapering under certain circumstances, including when the resident's clinical condition has improved or stabilized.

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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** 48678 Based on interview and record review, the facility failed to perform a gradual dose reduction (GDR - a periodic attempt to manage a resident's behavioral issues with a lower dose of medication) related to the use of Seroquel (a medication used to treat psychosis) or document a clinical rationale as to why an attempt would be contraindicated for one of five sampled residents (Resident 52.) The deficient practice increased the risk for Resident 52 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to Seroquel therapy possibly leading to impairment or decline in the resident's mental, physical, and /or psychosocial status. Findings: During a review of Resident 52's Admission Record (a document containing diagnostic and demographic information), dated 12/18/0224, the Admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and psychosis (a mental disorder characterized by a disconnection from reality). During a review of Resident 52's Minimum Data Set (MDS- a standardized resident assessment tool), dated 11/8/2024, the MDS indicated Resident 52 was taking an antipsychotic in the last seven days or since admission on a routine basis, and a GDR had not been attempted, and a GDR had not been documented by a physician as clinically contraindicated. The MDS indicated Resident 52 did not have any potential indicators of psychosis. Resident 52 did not have mood or behavioral symptoms. The MDS indicated Resident 52 had severe cognitive skills (a condition that makes it difficult for a person to remember, learn, concentrate, or make decisions that affect their daily life) for daily decision making. The MDS indicated Resident 52 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) from staff for upper and lower body dressing, personal hygiene, putting on footwear, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and transfer from chair to bed. The MDS indicated Resident 52 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting and showering. During a concurrent interview and record review of Resident 52's Psychotropic (relating to or denoting drugs that affect a person's mental state) Summary Sheet (a monitoring log of behavioral episodes of residents who are on psychotropic medication) on 12/17/2024 at 12:21 AM with the Assistant Director of Nursing (ADON), the ADON verified that the Psychotropic Summary Sheet indicated Resident 52 had zero episodes of psychosis for the months of March, April, May, June, July, August, and September 2024. During a review of Resident 52's Order Summary Report (a summary of all currently active physician orders), dated 3/28/2024, the Order Summary Report indicated Seroquel 25 milligrams (mg - a unit of measure for mass) by mouth at bedtime for psychosis manifested by responding to internal stimuli thinking she works in the facility. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the consultant pharmacist's recommendation, dated 6/10/2024, the pharmacist's recommendation indicated a note to the attending physician to consider if a dose change for Resident 52's Seroquel 25 mg was warranted at this time due to psychoactive medications must undergo a psychotropic drug regimen review with evaluation for dose reduction every six months for the first year and annually thereafter. During a review of Resident 52's clinical record, there was no documentation found indicating the physician responded to the consultant pharmacist's request to consider a GDR for Seroquel or any other indication the dose of Seroquel had changed since 3/8/2024. During an interview on 12/19/2024 at 10:46 AM, with the ADON, the ADON stated the facility failed to ensure the physician responded to the consultant pharmacist's request to decrease the dose of Seroquel for Resident 52. The ADON stated there is no record of a specific response to the pharmacist's request or any other record that addresses the dosage of Seroquel. The ADON stated Resident 52 has been on the same dose since March of 2024. The ADON stated the facility failed to decrease Resident 52's Seroquel dose or document a resident-specific reason/s why a dosage reduction would be contraindicated. The ADON stated the failure to consider a GDR or respond to the pharmacist's request for GDR increased the risk that Resident 52 may experience adverse effects of Seroquel, such as tardive dyskinesia (a condition affecting the nervous system, such as uncontrollable jerky movements of the face and body often caused by long-term use of some psychiatric drugs), cognitive impairment, tremors, drooling, rigidity, due to using a higher dose than necessary which could have negatively impacted her quality of life. During a review of the facility's policy and procedure (P&P) titled, Tapering Medication and Gradual Drug Dose Reduction , revised April 2024, the policy indicated, The physician will review periodically whether current medication are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or enduring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medication, or with a lower dose . The physician will order appropriate tapering of medication, as indicated . The policy indicated the staff and practitioner will consider tapering under certain circumstances, including when the resident's clinical condition has improved or stabilized.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48678

Based on observation, interview, and record review, the facility failed to ensure dry food items that had been removed from their original packaging were labeled with use by date, and refrigerated foods that had expired were discarded.

This deficient practice resulted in exposing residents to expired food items, affecting the quality, taste, and texture of food, and potentially harming residents if they consumed expired food.

Findings:

During a concurrent observation in the facility's kitchen and interview on [DATE] at 8:16 AM with the Dietary Supervisor (DS), the DS picked up a package of assorted sugar free beverage crystals and stated the package was not labeled with a use by date to indicate when the product expired/ will expire. The DS added, It was no longer good for human consumption. The DS stated the package had been taken out of its original packaging and should have been labeled with use by date by the person who removed it from the original package. The DS stated it was important to label the food with use by date to ensure it was safe for human consumption and expired items are discarded. The DS stated there are two staff in the kitchen responsible for labeling packages with a delivery date, open date, and expiration or use by date, and discarding expired food items twice a week, on Tuesdays and Thursdays.

During a concurrent observation in the facility's dry food storage kitchen and interview on [DATE] at 8:27 AM with the DS, a loaf of bread whole grain bread with expiration date of [DATE]. The DS stated the bread should have been discarded since it was past the expiration/ use by date, and if residents consumed it, it could cause gastrointestinal issues for residents or change the texture of the bread by making it stale.

During a concurrent observation in the facility's dry storage room and interview on [DATE] at 8:39 AM with the DS, the DS stated two jars of pear honey and ginger jelly were stored in the dry storage room without a label of use by date or expiration date.

During a concurrent observation in the facility's kitchen and interview on [DATE] at 8:45 AM with the DS, the DS stated there was a box of frozen bread in the freezer with a delivery date of [DATE] and a use by date of [DATE]. DS stated the expired bread should not be in the refrigerator and should have been discarded to prevent anyone from eating expired bread.

During a concurrent observation in the facility 's kitchen and interview on [DATE] at 9:12 AM with the DS, DS stated the freezer contained a box of frozen crab cakes containing blue crab did not have a label with a use by date and did the DS does not know if the item was safe for human consumption. DS stated, the DS would need to call the company to obtain a use by date for the crab cakes. DS also stated she did not have this particular item listed on their kitchen food item guidelines to indicate how long the food was safe for consumption.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy titled, Food Receiving and Storage, dated [DATE], the policy indicated dry foods that are stored in bins are removed from original packaging, labeled, and dated with use by date. All foods stored in the refrigerator or freezer are covered, labeled, and dated with use by date, are monitored so they are used by their use by date or discarded.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 44018 Based on observation, interview, and record review, the facility failed to ensure garbage was disposed properly for one of two dumpsters as indicated on the facility policy. This deficient practice had a potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) that could potentially infiltrate the facility, affect the resident care areas and pose a disease threat to the residents and staff of the facility. Findings, During a concurrent observation and interview on 12/17/2024 at 1:19 PM with Infection Prevention Nurse (IPN), there were two dumpsters in a corner outside the facility by the facility parking lot. One dumpster was observed not covered and another dumpster was not covered and was overflowing with garbage. IPN stated both dumpsters needed to be covered because the garbage could harbor pests. IPN stated it could cause the spread of infection and affect staff and the residents. During an interview on 12/18/2024 at 2:18 PM with the Administrator (ADM), ADM stated keeping the garbage area clean is the responsibility of the maintenance staff and kitchen staff. ADM stated dumpsters' cover should be kept closed and it should not be filled with garbage above the full line. ADM stated this had the potential for pest and other insects' infestation, which could affect the residents and staff's health. During a review of the facility's policies and procedures (P&P) titled, Food-Related Garbage and Refuse Disposal, revised date October 2017, indicated), the P&P indicated all garbage and refuse containers (moveable container for storing and disposing of waste such as garbage) are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. It also indicated garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and /or diseases in the healthcare setting) were followed in accordance with the facility's policy and procedure for two of 14 sampled residents (Residents 126 and 273) in accordance with the facility policy by failing to ensure: 1. Resident 126's used urinal with urine was not placed next to the uncovered cup of water and a cup of oatmeal on the resident's bedside table. 2. Resident 273's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag was not touching the floor. This deficient practice placed the Resident 126 at risk for potential infection. Findings: 1. During a review of Resident 126's Admission Record, the Admission Record indicated Resident 126 was admitted to the facility on [DATE] with diagnoses including hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood) and hypertensive (high blood pressure) heart disease without heart failure. During a review of Resident 126's History and Physical Examination (H&P), dated 12/16/2024, the H&P indicated Resident 126 had the capacity to understand and make decisions. During an observation in Resident 126's room and interview on 12/16/2024 at 10:12 AM, Resident 126's used urinal with urine was observed next to an open/uncovered cup of water and an open/ uncovered cup of oatmeal on the bedside table. Resident 126 stated he asked the Certified Nurse Assistant (CNA) to empty the urinal around 9 AM. During a concurrent observation and interview with Licensed Vocational Nurse 2 (LVN 2) on 12/16/2024 at 12:03 PM, LVN 2 stated Resident 126's urinal should have been emptied and not left by the resident's food. During an interview with Director of Nursing on 12/16/2024 at 12:02 PM, the DON stated the urinal should not be placed next to the resident's food. The DON stated staff should dedicate an area like the siderail (are adjustable metal or rigid plastic bars that attach to the bed) that is within easy reach of the urinal but away from food. The DON also stated it was important to keep the urinal away from food to maintain hygiene and prevent potential contamination. During a review of facility's policy and procedure (P&P) titled, Infection Prevention Quality Control Plan, revised October 2023, the P&P indicated the facility shall provide guidelines for general infection control while caring for residents. Standard Precaution would be used in the care of all residents in all situations. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether they contain visible blood, non-intact skin, and/or mucous membranes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48903 2. During a review of Resident 273's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), acute kidney failure (a sudden loss of kidney function that occurs over a short period of time), and sepsis (a life-threatening blood infection). During a review of Resident 273's History and Physical (H&P), dated 12/14/2024, the H&P indicated Resident 273 had the capacity to understand and make decisions. During a review of Resident 273's Order Summary Report, dated 12/12/2024, the Order Summary Report indicated Resident 273 had an order for indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine). During a concurrent observation and interview on 12/16/2024 at 1:43 PM with Registered Nurse 1 (RN 1), Resident 273's indwelling catheter collection bag was observed touching the floor. RN 1 stated, The indwelling catheter collection bag is touching the floor. It shouldn't be touching the floor because it puts the resident at risk of getting an infection. During a concurrent interview and record review on 12/18/2024 at 11:56 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Catheter Care, Urinary dated 9/2014 was reviewed. The P&P indicated: 1. The purpose of this P&P is to prevent catheter associated urinary tract infections (UTI, condition in which bacteria invade and grow in any part the urinary system which includes the kidneys, bladder, ureters [tube that carries urine from the kidney to the urinary bladder], and urethra [canal from the bladder]). 2. Infection Control: be sure the catheter tubing and drainage bag are kept off the floor. DON stated that an indwelling catheter touching the floor can cause an infection to the resident and it should not be touching the floor.