STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055527	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Palos Post-Acute Care Center	1430 West 6th Street San Pedro, CA 90732

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one sampled resident (Resident 82) Minimum Data Set (MDS - a resident assessment tool) section H was coded accurately to reflect Resident 82 was not incontinent (experiencing the involuntary loss of urine or stool). This failure resulted in Resident 82's MDS being coded incorrectly and had the potential to result in a loss of dignity for Resident 82. Findings: During a review of Resident 82's admission Record (Face Sheet), the Face Sheet indicated Resident 82 was admitted to the facility on [DATE] with diagnoses of but not limited to diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), myocardial infarction(MI-heart attack), broken left arm and hypertension(HTN-high blood pressure). During a review of Resident 82's Interdisciplinary Team (a group of professional from different disciplines or fields who work together towards a common goal)-Plan of Care Meeting Notes, dated 1/3/2025, the Interdisciplinary Team-Plan of Care Meeting Notes indicated Resident 82 had the capacity to make decisions and able to make needs known. During a review of Resident 82's MDS dated [DATE], the MDS indicated Resident 82 had the ability to express ideas and wants. The MDS indicated Resident 82 had the ability to understand others. During an interview on 5/8/2025 9:48 AM with Certified Nurse Assistant (CNA) 4, CNA 4 stated Resident 82 is not incontinent of bowel and bladder. CNA 4 stated Resident 82 does not use diapers and does not need assistance with the bathroom. CNA 4 stated Resident 82 uses a urinal. During an interview on 5/8/2025 11:53 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 82 is continent of bowel and bladder. During an interview on 5/8/2025 at 2:31 PM with Minimum Data Set Nurse (MDSRN), MDSRN stated she is responsible for completing the MDS assessment for all of the residents in the facility. MDSRN stated she reviewed comprehensive care plans initial IDT meeting with the family to complete the MDRS for section H. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 2:49 PM with Resident 82 and the MDSRN at Resident 82's bedside, Resident 82 stated he is not incontinent. Resident 82 stated the problem is I was not getting help in a timely manner so they put diapers on me at night so I would not have had an accident. MDSN stated she will do a reassessment and in-service the certified nursing assistance on how to document bowel and bladder. MDSRN stated Resident 82 had the urge to urinate and have a bowel movement, so he is continent. During an interview on 5/9/2025 at 4:25 PM the Director of Nursing (DON), DON stated it is important to document accurately on the MDS so there will be no discrepancies. DON stated discrepancies on the MDS can affect the residents' wellbeing. The DON stated Resident 82 will not receive proper care due to incorrect documentation on the MDS. During a review of the facility's policy and procedure (P&P) titled, Urinary Continence and Incontinence - Assessment and Management, dated 8/2022, the P&P indicated Periodically (as required and when there is a change in voiding), staff will define each individual's level of continence, referring to the criteria in the Minimum Data Set (MOS), as follows, Continent: The resident has been continent of urine for at least 7 days, with no episodes of incontinence.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of three sampled residents (Resident 78) by failing to: 1.Develop a comprehensive person-centered care plan to address Resident 78's toe infection. This failure had the potential to negatively affect the delivery of care and services to Resident 78. Findings: During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 78's Minimum Data Set (MDS- a resident assessment tool) dated 2/28/2025, the MDS indicated Resident 78's cognition (ability to think, understand, learn, and remember) was severely impaired and required supervision with toileting and dressing. During a review of Resident 78's Order Summary Report, the Order Summary Report indicated an order was placed 5/6/2025 for Doxycycline Hyclate (medication to treat an infection) for left second toe cellulitis (a skin infection that causes swelling and redness). During an interview on 5/7/2025 at 12:18 p.m., with Infection Prevention Nurse (IPN), the IPN stated when a new infection is identified, the residents care plans should be implemented or revised. IPN stated the care plan is important because it is a form of communication between the nurses on how and what to monitor for. IPN stated Resident 78's care plan was not implemented or revised for this toe infection which should have been done at the time the infection was identified. During an interview on 5/8/2025 at 10:10 a.m., with Licensed Vocational Nurse (LVN) 4, LVN stated she did not initiate a care plan for Resident 78's toe infection. LVN 4 stated its important to initiate or revise a care plan to ensure there are interventions in place that will help the residents get better and improve. Care plans are used to make sure the problems for the residents are being addressed and she should have revised Resident 78's care plan when his toe infection was identified. During an interview on 5/9/2025 at 1:38 p.m., with the Director of Nursing (DON), the DON stated that when a resident develops a wound infection, a care plan should be implemented at the time it is identified. The DON stated the care plan is an important guideline of interventions for the nursing staff to follow and a way to monitor the progression of wound healing. (continued on next page)

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F 0656 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, Goals and Objectives, Care Plans, dated 4/2009, the P&P indicated, Care plan goals and objectives are defined as the desired outcomes for a specific resident problem. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident 9's Ciprodex otic (ear) ([generic name - ciprofloxacin and dexamethasone] a medication used to treat ear infection and inflammation) suspension was administered per professional standards of practice and as per facility's policy and procedure (P&P) titled, Specific Medication Administration Procedures - Ear Drop Administration, dated 05/2022, for one of seven sampled residents during medication administration (Resident 9). This failure had the potential to result in Resident 9's discomfort and untreated ear infection. Findings: During a review of Resident 9's admission Record (a document containing demographic and diagnostic information), dated 5/8/2025, the admission Record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (nerve damage due to diabetes) and other benign neoplasm of skin of right ear and external auricular canal (abnormal mass of tissue in external ear canal). During a review of Resident 9's Minimum Data Set ([MDS], a resident assessment tool) dated 3/28/2025, the MDS indicated Resident 9 had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated that Resident 9 needed cleaning assistance from facility staff for activities of daily living (ADLs) such as eating, supervision assistance for oral hygiene, moderate assistance for upper body dressing, maximal assistance for toileting, showering, lower body dressing and personal hygiene, and dependent on facility staff for putting on or taking off footwear. During a review of Resident 9's Order Summary Report (a document containing a summary of all active physician orders), dated 5/8/2025, the Order Summary Report indicated, but not limited to the following physician order: Ciprofloxacin-dexamethasone otic suspension 0.3%-0.1%, instill four drops in the right ear two times a day for ear infection for 7 days, order date 5/5/2025, start date 5/6/2025, end date 5/13/2025 During an observation on 5/7/2025 between 10:35 a.m. and 10:50 a.m. in Resident 9's room, Licensed Vocational Nurse (LVN) 2 prepared and administered ciprofloxacin 0.3% plus dexamethasone 0.1% ear suspension for Resident 9. LVN 2 was not observed shaking the ear suspension prior to administration. LVN 2 told Resident 9 to keep her head and neck tilted to her left side while seated in wheelchair. LVN 2 instilled one drop of ciprofloxacin-dexamethasone into Resident 9's right ear. LVN 2 informed Resident 9 to keep her neck and head tilted in the same position for five minutes after which LVN 2 would resume to instill next drop. LVN 2 followed the same steps to instill total of four drops into Resident 9's right ear by waiting five minutes between each drop, taking a total of 20 minutes to complete medication administration. Resident 9 complained of her neck hurting throughout the process of receiving ciprofloxacin-dexamethasone ear drops. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 11:10 a.m. with LVN 2, LVN 2 stated they were informed during a facility in-service to keep a five-minute interval between each drop instilled into the ears for adults. LVN 2 stated it took 20 minutes to administer Resident 9's ciprofloxacin with dexamethasone ear drops. LVN 2 stated she thought she had shaken the suspension before being observed for medication pass. LVN 2 stated it was important to shake the suspension for the medication to be effective for treatment of ear infection. During a concurrent interview and record review on 5/8/2025 at 4:28 p.m. with the Director of Nursing (DON), reviewed facility's P&P titled, Specific Medication Administration Procedures - Ear Drop Administration, dated 05/2022. The P&P indicated, Procedures - F. Instill the prescribed number of drops into the ear canal. Do not touch the tip of the dropper to any surface, including the ear. H. Instruct the resident to remain in same position approximately 5 minutes with affected ear upward. The DON stated ciprofloxacin with dexamethasone ear drops should have been given as four drops and then wait five minutes to make sure the medication was administered into the ear. The DON stated the resident could get a stiff neck from keeping her neck tilted for a long time due to facility nurse's instructions to wait five minutes between each drop. The DON stated Resident 9 could get tired and might not want the medication administered next time and could worsen the ear infection. During a review of the facility's P&P titled, Specific Medication Administration Procedures - Ear Drop Administration, dated 05/2022, the P&P indicated, Procedures - F. Instill the prescribed number of drops into the ear canal. Do not touch including the ear. H. Instruct the resident to remain approximately 5 minutes with affected ear upward. Gently place if necessary.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pressure ulcer treatment for left buttock Stage 4 pressure ulcer (wound that penetrate all layers of skin exposing muscles, tendons [tissue that unites a muscle with a bone] cartilage {tissue that lines a joint}, and bones caused by prolonged pressure on the skin) on 5/8/2025, as indicated in the resident's physician orders for one of one sampled residents (Resident 1) . This deficiency had the potential for Resident 1's left buttock Stage 4 pressure ulcer to worsen, to develop new pressure injury, and had the potential to develop infection. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including anoxic brain injury (occurs when the brain receives no oxygen at all and causes brain damage), functional quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs [extremities] and the torso {upper part of the body}), and a Stage 4 pressure ulcer to the left buttock. During a review of Resident 1's History and Physical (H& P) dated 3/25/2021, the H&P indicated Resident 1 was not able to express needs, communicate, and could not follow commands. During a review of Resident 1's Minimum Data Set ([MDS] resident assessment tool) dated 4/1/2025, the MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for bed mobility, moving from sitting on side of bed to lying flat on bed, toileting hygiene, bathing, dressing, personal hygiene, and oral hygiene. The MDS indicated Resident 1 had a Stage 4 pressure ulcer on the left buttock. During an observation on 5/8/2025 at 8:18 a.m. in Resident 1's room with Treatment Nurse (TN 1) and Certified Nurse Assistant (CNA 1), observed TN 1 cleaning the surrounding skin area of the left buttock pressure ulcer and applying Santyl ointment (a smooth thick substance that is put on sore skin or a wound to help it heal). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/8/2025 at 8:20 a.m. with TN 1, reviewed Resident 1's Treatment Administration Record (TAR), dated 4/2025. The TAR indicated, left buttock Stage 4 treatment to cleanse with normal saline (NS - cleanser), apply Medi Honey (ointment used for wound care, particularly for difficult-to-heal wounds) on wound bed and barrier cream on pre-wound daily every day shift for 21 days. TN 1 stated that she applied Santyl ointment instead of Medi Honey as ordered by Resident 1's doctor. TN 1 stated that she used the Santyl ointment because she had used it before on Resident 1's wound. TN 1 stated doctors' orders should have been reviewed before performing pressure ulcer treatment to Resident 1 to ensure the treatment and interventions were coordinated with Resident 1's plan of care. TN 1 stated prior to administering medications she should verify the five rights of medication administration (set of guidelines that healthcare professionals use to ensure medication safety and reduce the risk of errors) which included right resident, right medication, right time, right dose, and the right route. TN 1 stated by Resident 1 not receiving the correct treatment during pressure ulcer treatment directly impacts her well-being and had the potential delay in Resident 1's pressure ulcer healing. During an interview on 5/9/2025 at 4:44 p.m. with the Director of Nursing (DON), the DON stated that licensed staff should always review the doctors' orders before performing care to residents. The DON stated errors could occur and possibly death if the staff do not follow the doctors' orders. The DON stated it was imperative when performing wound treatment that the resident receives the correct medication because their pressure ulcer might not heal. The DON stated Resident 1 could be at risk for complications like infection, delayed wound healing, and tissue damage, which could cause her to be hospitalized . During a review of Resident 1's Order Summary Report dated 4/16/2025, the Order Summary Report indicated an order for left buttock Stage 4 treatment to cleanse with normal saline (wound cleanser), apply Medihoney (ointment used to treat pressure ulcer) on wound bed and barrier cream on peri-wound (surrounding) daily. During a review of Resident 1's Treatment Administration Record (TAR), dated 4/16/2025, the TAR indicated a treatment for left buttock Stage 4, cleanse with NS, apply Medi honey on wound bed and barrier cream on peri-wound daily every day shift for 21 days. During a review of Resident 1's Administration History for Medi Honey, the Administration History indicated the following: 1.Administer Medi Honey on 4/17/2025 at 11:21 a.m. 2.Administer Medi Honey on 4/18/2025 at 12:13 p.m. 3.Administer Medi Honey on 4/19/2025 at 2:05 p.m. 4.Administer Medi Honey on 4/20/2025 at 3:24 p.m. During a review of Resident 1's Skilled Nursing Facility (SNF) Wound Care Record, dated 4/16/2025, the SNF Wound Care Record indicated, Plan: Cleanse with NS, apply Medi honey on the wound bed, and barrier cream on the peri-wound daily. (continued on next page)

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F 0686 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, Administering Medications, dated 2019, the P&P indicated, The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident, who had a Stage 4 pressure ulcer (wound that penetrate all layers of skin exposing muscles, tendons [tissue that unites a muscle with a bone] cartilage {tissue that lines a joints}, and bones caused by prolonged pressure on the skin) to left buttock (the back of a hip that forms one of the fleshy parts on which a person sits), did not experience unnecessary pain and suffering during pressure ulcer treatment and repositioning for one of one sampled resident (Resident 1). The facility failed to: 1. Ensure the Treatment Nurse (TN 1) stopped providing Resident 1 with left buttock pressure ulcer treatment when Resident 1 had facial grimacing (a facial expression where the mouth and face are twisted, often to indicate disgust, disapproval, or pain) and was moaning during treatment. 2. Ensure Licensed Vocational Nurse (LVN) 4 medicated Resident 1 with Tylenol (pain medication) 500 milligrams (mg-unit of measurement) one hour before a left buttock pressure ulcer treatment as ordered by the physician. 3. Ensure TN 1 and TN 2 checked if Resident 1 received Tylenol one hour before providing the resident with pressure ulcer treatment to the left buttock. 4. Ensure TN 1, TN 2 and LVN 4 followed Resident 1's care plan titled, Care Plan Report dated 10/2024, that indicated the goal for Resident 1 was not to experience facial grimacing if pain existed. 5. Ensure Resident 1 received treatment for a left buttock pressure ulcer within one hour after Tylenol administration to lessen possible experience of pain and/or discomfort. 6. Ensure staff followed the facility's policy and procedures (P&P) titled, Pain Assessment and Management, dated 2022, which indicated Observe the resident during rest and movement for physiologic (functions of the body) and behavioral (non-verbal) signs of pain such as groaning, crying, screaming, facial grimacing, frowning, behavior such as resisting care, irritability, or depression (loss of interest in activities, causing significant impairment in daily life). Review resident's treatment record to identify any situations or interventions where an increase in the resident's pain may be anticipated such as treatment like wound care or dressing changes. These deficient practices resulted in Resident 1's experiencing unrelieved, and uncontrolled pain manifested by facial grimacing and moaning during pressure ulcer treatment. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including anoxic brain injury (occurs when the brain receives no oxygen at all and causes brain damage), functional quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs [extremities] and the torso {upper part of the body}), and a Stage 4 pressure ulcer to the left buttock. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's History and Physical (H& P) dated 3/25/2021, the H&P indicated Resident 1 was not able to express needs, communicate, and could not follow commands. During a review of Resident 1's Minimum Data Set ([MDS] resident assessment tool) dated 4/1/2025, the MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for bed mobility, moving from sitting on side of bed to lying flat on bed, toileting hygiene, bathing, dressing, personal hygiene, and oral hygiene. The MDS indicated Resident 1 had a Stage 4 pressure ulcer on the left buttock. During an observation on 5/7/2025 at 8:21 a.m. in Resident 1's room, the resident was observed in bed lying on her back with her eyes open. Resident 1 was nonverbal (doesn't use spoken words) and responsive to tactile stimuli (any form of touch or physical contact that is perceived by the skin). During an interview on 5/7/2025 at 4:00 p.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated Resident 1 was nonverbal and dependent with care (refers to the care and support provided for individuals who are unable to care for themselves) for activities of daily living ([ADL's]- basic tasks everyone performs daily to care for themselves, like eating, dressing, bathing, and moving around). CNA 2 stated Resident 1 had a pressure ulcer to her left buttock. CNA 2 stated that he observed Resident 1 had facial grimacing and moaning during personal care and pressure ulcer treatments to her left buttock. CNA 2 stated the Treatment Nurse (TN 1) continues to perform the pressure ulcer wound treatment in spite of Resident 1 having facial grimacing and moaning. CNA 2 stated when Resident 1 makes facial grimacing and moaning that indicates that Resident 1 was in pain. CNA 2 stated that TN 1 should have given Resident 1 pain medication prior to each pressure ulcer treatment. CNA 2 stated he had not reported Resident 1 facial grimacing and moaning during pressure ulcer treatment to the charge nurse because Resident 1 always had facial grimacing and moaning during pressure ulcer treatment. CNA 2 stated that he should have reported Resident 1's facial grimacing during pressure ulcer treatment to a charge nurse. During an observation on 5/8/2025 at 8:18 a.m., in the presence of TN 1 and CNA 1, in Resident 1's room, Resident 1 was observed with facial redness, moaning and facial grimacing when Resident 1 was repositioned. After being repositioned observed TN 1 started wound treatment to Resident 1's left buttock pressure ulcer. Resident 1 was observed moaning louder when TN 1 started vigorously cleaning the surrounding skin area of the left buttock pressure ulcer and applying Santyl ointment (a smooth thick substance that is put on sore skin or a wound to help it heal). TN 1 was observed continuing with Resident 1's left buttock pressure ulcer treatment even after Resident 1 continued to moan and grimacing. Resident 1 was observed to stop having facial grimacing and moaning only after when TN 1 finished the pressure ulcer treatment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/8/2025 at 8:20 a.m. with TN 1, TN 1 stated Resident 1 was nonverbal, responsive to tactile stimulation, and was dependent on ADL. TN 1 stated Resident 1 had a Stage 4 pressure ulcer to her left buttock and was receiving pressure ulcer treatment daily. TN 1 stated Resident 1 appeared to be in pain because she had facial grimacing and moaning during pressure ulcer treatment. TN 1 stated facial grimacing and moaning were the indicators that Resident 1, who was nonverbal, was experiencing pain and was uncomfortable. TN 1 stated she should have stopped the pressure ulcer treatment, assessed Resident 1's pain level, including the non-verbal cues, like facial grimacing, notified the physician, and medicated Resident 1 with pain medication. TN 1 stated she did not know why she continued with the pressure ulcer treatment in spite Resident 1's moaning and facial grimacing. TN 1 stated Resident 1 should be assessed for pain before, during, and after treatment, because Resident 1 could be experiencing pain during pressure ulcer treatment. TN 1 stated Resident 1 should have been pre medicated with Tylenol (medication to relieve pain) one hour prior to pressure ulcer treatment per physician order. TN 1 stated she failed to verify with Licensed Vocational Nurse (LVN) 4, if Resident 1 had been pre medicated with Tylenol prior to pressure ulcer treatment. During an interview on 5/8/2025 at 9:27 a.m. with LVN 4, LVN 4 stated Resident 1 was nonverbal, and dependent with ADLs and had nonverbal cues of pain (moaning and facial grimacing) during provision of personal care and pressure ulcer treatment. LVN 4 stated Resident 1 should have received Tylenol 500 milligram (mg-unit of weight measurement) one hour before left buttock pressure ulcer treatment, for pain management. LVN 4 stated when nonverbal residents begin to moan and have facial grimacing during personal care or pressure ulcer treatment, that would be an indication that a resident was in pain. LVN 4 stated TN 1 should have stopped the pressure ulcer treatment immediately and reassess Resident 1's pain. LVN 4 stated Resident 1's doctor should also be notified because the intervention/medication may not be effective. LVN 4 stated Resident 1 should be assessed before, during and after wound treatment to manage her pain, because pain can negatively impact Resident 1's wellbeing. LVN 4 stated she forgot to give Resident 1 pain medication on 5/8/2025 prior to Resident 1's pressure ulcer wound treatment. During a concurrent interview and record review on 5/9/2025 at 11:35 a.m. with TN 2, Resident 1's Treatment Administration Record (TAR), dated 5/2025 was reviewed. The TAR indicated, on 5/7/2025, at 3:39 p.m., TN 2 performed wound treatment to Resident 1's left buttock pressure ulcer. TN 2 validated that she provided wound treatment without Resident 1 receiving Tylenol prior to pressure ulcer treatment. TN 2 stated Resident 1 had a Stage 4 pressure ulcer to her left buttock, and she should have received Tylenol one hour prior to pressure ulcer treatment to the left buttock. TN 2 stated Resident 1 was non-verbal, and during the wound treatment on 5/7/2025 Resident 1 had facial grimacing and moaning, which indicated Resident 1 was in pain. TN 2 stated the pressure ulcer treatment should have been stopped, and the charge nurse should have been notified. TN 2 stated she continued with the pressure ulcer treatment in spite Resident 1's moaning and facial grimacing because it was going to be done quickly. TN 2 stated that after the treatment Resident 1 stopped grimacing and moaning, which indicated that she was no longer in pain. TN 2 stated Resident 1 should have been assessed for pain before, during and after treatment to ensure she was not in pain because that could affect her quality of life. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/9/2025 at 4:44 p.m. with the Director of Nursing (DON), the DON stated that when residents receive pressure ulcer treatment the nurse should assess resident pain before, during and after treatment. The DON stated for nonverbal residents the staff should observe behaviors such as facial grimacing, frowning, moaning, and crying. The DON stated if a resident exhibits those types of behaviors during pressure ulcer treatment the nurse should stop treatment immediately and contact the doctor. The DON stated unmanaged pain could negatively affect the residents' blood pressure, leading to a high risk of hypertension (high blood pressure) which can ultimately cause a heart attack (supply of blood to the heart is suddenly blocked), stroke (lack of adequate blood supply to the brain), or even death. During a review of Resident 1's Order Summary Report, dated 5/7/ 2024, the Order Summary Report indicated, to monitor for pain before, during, after wound treatment, every day shift for pain management. During a review of Resident 1's Order Summary Report, dated 1/17/2025, the Order Summary Report indicated, Tylenol 500 mg one tablet every day shift for pain management one hour prior to wound treatment. During a review of Resident 1's Care Plan titled, Resident 1 totally dependent with all ADLs, at risk for pain during turning, facial grimaces if pain existed dated 10/17/2024, the Care Plan indicated the goal for Resident 1 was not to experience pain during turning and facial grimaces if pain existed. The care plan interventions included to monitor resident for inability to express needs, pain during turning and facial grimaces if pain existed. During a review of Resident 1's Care Plan titled, Resident 1 has slow wound healing on left buttock dated 10/17/2024, the care plan indicated the interventions indicated to assess Resident 1 for pain every shift and provide interventions for pain. During a review of Resident 1's Medication Administration Record (MAR) and Treatment Administration Record (TAR), the MAR and TAR indicated that pressure ulcer treatment was not provided in one hour after Tylenol administration to ensure Resident 1would have the most effective pain relief and it was as follows: 1. On 4/24/2025 Tylenol 500 mg was given at 9:16 a.m., but left buttock pressure ulcer treatment was done at 1:36 p.m. 2. On 4/25/2025 Tylenol 500 mg administered at 9:47 a.m., but left buttock pressure ulcer treatment was done at 2:41 p.m. 3. On 4/27/2025 Tylenol 500 mg administered at 9:56 a.m., but left buttock pressure ulcer treatment was done at 2:54 p.m. p.m. 4. On 4/28/2025 Tylenol 500 mg administered at 9:51 a.m., but left buttock pressure ulcer treatment was done at 12:42 p.m. 5. On 4/29/2025 Tylenol 500 mg administered at 8:35 a.m., but left buttock pressure ulcer treatment was done at 12:53 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	6. On 4/30/2025 Tylenol 500 mg administered at 9:38 a.m., but left buttock pressure ulcer treatment was done at 11:39 a.m. 7. On 5/01/2025 Tylenol 500 mg administered at 8:55 a.m., but left buttock pressure ulcer treatment was done at 2:35 p.m. 8. On 5/2/2025 Tylenol 500 mg administered at 8:34 a.m., but left buttock pressure ulcer treatment done at 1:50 p.m. 9. On 5/4/2025 Tylenol 500 mg was administered at 8:41 a.m., but left buttock pressure ulcer treatment was done at 1:40 p.m. 10. On 5/5/2025 Tylenol 500 mg administered at 9:32 a.m., but left buttock pressure ulcer treatment was done at 1:40 p.m. 11. On 5/6/2025 Tylenol 500 mg administered at 8:49 a.m., but left buttock pressure ulcer treatment done at 2:22 p.m. 12. On 5/7/2025 Tylenol 500 mg administered at 10:40 a.m., but left buttock pressure ulcer treatment was done at 3:39 p.m. 13. On 5/9/2025 Tylenol 500 mg administered at 9:20 a.m., but left buttock pressure ulcer treatment was done at 3:43 p.m. During a review of Resident 1's Order Summary Report dated 4/16/2025, the Order Summary Report indicated an order for left buttock Stage 4 treatment to cleanse with normal saline (wound cleanser), apply Medihoney (ointment used to treat pressure ulcer) on wound bed and barrier cream on peri-wound (surrounding) daily. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated 2022, the P&P indicated to observe the resident during rest and movement for physiologic and behavioral (non-verbal) signs of pain. The P& P indicated possible behavioral signs of pain are verbal expressions such as groaning, crying, screaming, facial expressions such as grimacing, frowning, behavior such as resisting care, irritability, or depression. The P&P indicated to review resident's treatment record to identify any situations or interventions where an increase in the resident's pain may be anticipated such as treatment like wound care or dressing changes. During a review of the Charge Nurse/Nurse Supervisor Job Description, dated 2020, the Charge Nurse/Nurse Supervisor Job Description indicated, provide pain management for residents in accordance with established pain management protocols (referring to the Pain Assessment and Management P&P).

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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** Based on observation, interview, and record review, the facility failed to: 1. Ensure administration of metoprolol succinate (a medication used to treat hypertension [high blood pressure] and heart conditions) extended release (ER) within 60 minutes of its scheduled time as per facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 05/2022, affecting one of seven sampled residents during medication administration (Resident 27). 2. Clarify and discontinue Resident 27's duplicate orders for Voltaren ([generic name - diclofenac] a medication used topically to treat osteoarthritis [pain and inflammation of joints]) topical gel, affecting one of seven sampled residents during medication administration (Resident 27). 3. Maintain accurate medication administration records as per facility's P&P titled, Medication Administration - General Guidelines, dated 05/2022, affecting one of seven sampled residents during medication administration (Resident 27). 4. Ensure availability and/or administration of Resident 27's timolol ophthalmic solution (a medication used to treat glaucoma [progressive eye disease that damages optic nerve potentially leading to vision loss and blindness] and high eye pressure]), Alphagan P ophthalmic solution ([generic name - brimonidine] a medication used to treat glaucoma and high eye pressure), dorzolamide hydrochloride ophthalmic solution (a medication used to treat glaucoma and high eye pressure), artificial tears eye solution (eye drops used to treat dry eyes), and Resident 65's vitamin B-1 ([also known as thiamin] a vitamin used to treat low levels of vitamin B-1), in accordance with physician orders, affecting two of seven sampled residents during medication administration (Resident 27 and 65). 5. Ensure Resident 9's Ciprodex otic (ear) ([generic name - ciprofloxacin and dexamethasone] a medication used to treat ear infection and inflammation) suspension was administered per professional standards of practice and as per facility's P&P titled, Specific Medication Administration Procedures - Ear Drop Administration, dated 05/2022, affecting one of seven sampled residents during medication administration (Resident 9). 6. Maintain accurate documentation of Resident 9's Pregabalin (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat fibromyalgia {pain in muscles and soft tissues} related pain, neuropathic (nerve related) pain and a subset of seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) after it was administered, and Resident 83's Lacosamide (a medication used to treat epilepsy [recurring seizures]) during inspection of medication cart, on accountability record or controlled medication count sheet/controlled drug record ([CDR] - a document indicating perpetual inventory and administration of controlled substances, affecting two residents (Residents 9 and 83) in two of two inspected medication carts (Station 1 Medication Cart and Station 2 Medication Cart). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These deficient practices failed to provide medications in accordance with the physician's orders or professional standards of practice, maintain accurate documentation of controlled medications, represented a pattern of falsification of medication administration records, and had the potential to result in unintended use and loss of controlled medications, medication non-compliance, medication errors, hypertension, seizures, glaucoma, vision loss, ear infection and hospitalization for Residents 9, 27, 65 and 83. Findings: 1, 2, 3 and 4a. During a review of Resident 27's admission Record (a document containing demographic and diagnostic information), dated 5/8/2025, the admission record indicated, Resident 27 was originally admitted to facility on 2/28/2014 and readmitted on [DATE] with diagnoses including but not limited to primary osteoarthritis, right and left shoulder, essential (primary) hypertension, pain syndrome, retinal edema (fluid buildup in areas of the eye) and unspecified glaucoma. During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool) dated 3/29/2025, the MDS indicated, Resident 27 had intact cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated, Resident 27 was independent with eating, needed setup assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, supervision assistance for toileting hygiene, upper body dressing, putting on/taking off footwear and personal hygiene, and needed moderate assistance for showering and lower body dressing. During a concurrent observation and interview on 5/7/2025 at 8:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared eight medications to be administered to Resident 27 that did not include any eye drops. LVN 1 stated Resident 27's blood pressure was checked on 5/7/2025 at 8:50 a.m. which was recorded at systolic blood pressure ([SBP] the pressure caused by heart while contracting) of 136 millimeters of mercury (mmHg - a measurement of pressure) and diastolic blood pressure ([DBP] the pressure in the arteries when the heart rests between beats) of 70 mmHg, heart rate at 80 beats per minute and resident's pain was at 7 out of 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) at 8:50 a.m. During a medication reconciliation review on 5/7/2025 at 12:20 p.m., Resident 27's Order Summary Report (a document containing a summary of all active physician orders), dated 5/1/2025, 5/8/2025 and order details were reviewed. The order summary report indicated, but not limited to the following physician order scheduled to be administered daily at 7:15 a.m.: Metoprolol Succinate ER Tablet ER 24 hour 25 milligrams (mg - a unit of measurement for mass), give one tablet by mouth two times a day for hypertension. Hold if SBP less than 100 or pulse rate (PR) less than 60 beats per minute, give with meals (breakfast and dinner), order date 3/21/2025, start date 3/21/2025 The order summary report indicated Resident 27 also had the following medications scheduled to be administered daily at 9:00 a.m.: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Alphagan P Ophthalmic Solution 0.1% (Brimonidine tartrate), instill one drop in both eyes three times a day for glaucoma. Wait 5 minutes between administration of all other eye drops, order date 3/21/2025, start date 3/21/2025 Dorzolamide hydrochloride (HCl) solution 2%, instill one drop in both eyes two times a day for glaucoma supervised self-administration. Wait five minutes between administration of all other eye drops, order date 3/21/2025, start date 3/21/2025 Timolol maleate ophthalmic solution 0.5%, instill 1 drop in both eyes two times a day for glaucoma. Wait at least 10 minutes before applying another eye medication, order date 4/20/2025, start date 4/21/2025 Artificial Tears Solution 1% (carboxymethylcellulose sodium), instill 2 drops in both eyes two times a day for dry eye syndrome (a condition where the eyes do not produce enough tears) . Wait at least five minutes before applying another eye medication, order date 3/21/2025, start date 3/21/2025 Diclofenac Sodium Gel 1%, apply to apply one gram (gm - a unit of measurement for mass) to both hands topically (applied to the surface of the body, typically the skin) two times a day for bilateral (both) hands osteoarthritis, order date 3/21/2025, start date 3/21/2025. Diclofenac Sodium Gel 1%, apply to left shoulder topically three times a day for shoulder pain, order date 2/14/2021, start date 2/15/2021 Voltaren External Gel 1% (diclofenac sodium topical), apply to bilateral shoulder topically three times a day for osteoarthritis, order date 3/21/2025, start date 3/21/2025 During a concurrent interview and record review on 5/7/2025 at 1:54 p.m. with RN Supervisor (RNS) 1, the order details and medication administration details of Resident 27's metoprolol succinate ER 25 mg were reviewed. RNS 1 stated Resident 27's metoprolol succinate ER 25 mg was administered more than 60 minutes after its scheduled administration time, so it would be considered late administration. RNS 1 stated Licensed Vocational Nurse (LVN) 1 should have administered the medication on 5/7/2025 by 8:15 a.m. because it was scheduled to be administered on 5/7/2025 at 7:15 a.m., but it was administered by LVN 1 at 9:00 a.m. RNS 1 stated Resident 27's blood pressure would not be managed well, increasing the risk for high blood pressure, stroke (loss of blood flow to a part of the brain) headache, nausea and vomiting. During a review of Resident 27's administration history for metoprolol succinate ER 25 mg, dated 4/23/2025 to 5/7/2025, the document indicated metoprolol succinate ER 25 mg was not administered within 60 minutes of scheduled time of 7:15 am for 10 times. (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 concurrent interview and record review on 5/7/2025 at 2:06 p.m. with LVN 1, Resident 27's administration details for diclofenac gel 1%, Alphagan P 0.1% ophthalmic solution, dorzolamide 2% ophthalmic solution, timolol 0.5% ophthalmic solution and artificial tears 1% solution and self-administration assessment were reviewed. The document indicated dorzolamide was documented as administered on 5/7/2025 at 8:54 a.m., timolol was documented as administered on 5/7/2025 at 8:55 a.m., Alphagan P was documented as administered on 5/7/2025 at 9:00 a.m. and 12:31 p.m., artificial tears were documented as administered on 5/7/2025 at 9:01 a.m. The review of Resident 27's self-administration assessment document, dated 3/29/2025, indicated Resident 27 was unable to self-administer medications. The document indicated physician order that indicated, Resident may not self-administer medications, medications given by licensed nurse on duty. At first, LVN 1 stated he administered the eye drops at or around 9:00 a.m., then stated he did not administer them. LVN 1 stated Resident 27 self-administered eye medications that included Alphagan P, timolol, dorzolamide and artificial tears. LVN 1 then reviewed the self-administration assessment document and stated Resident 27 was not supposed to keep any medications with her or self-administer medications because she was assessed to be unable to self-administer medications. LVN 1 stated the medications that were supposed to be self-administered would be given to the resident at the time of administration, but LVN 1 did not have those eye drops for Resident 27 in his medication cart, because the resident kept them at bedside. LVN 1 stated he did not remember when the last time he observed Resident 27 administer eye drops to herself. LVN 1 stated he was not supposed to document the medications as administered when they were not administered, and this would be considered as falsification of medical records. LVN 1 stated by missing her eye medications, Resident 27 was at risk for eye complications, worsening of glaucoma and disease progression. LVN 1 stated there were multiple orders for Resident 27's diclofenac topical gel that was used for shoulder pain and hands. LVN 1 stated the duplicate orders should have been clarified with physician and discontinued to prevent medication errors and overuse of the medication. During a concurrent observation and interview on 5/7/2025 at 3:05 p.m. in Resident 27's room with LVN 1, dorzolamide 2% eye drops, brimonidine (Alphagan P) 0.1% and Lumigan 0.01% ([generic name - bimatoprost] a medication used to treat glaucoma and high eye pressure) were found at resident's bedside. LVN 1 stated he would remove the medications from Resident 27's bedside because there was a risk for unsafe and incorrect administration of eye drops by the resident because the facility's assessment for self-administration indicated that Resident 27 was unable to self-administer. LVN 1 stated he did not have timolol and artificial tears in stock and would need to reorder all of Resident 27's eye drops from the pharmacy. During an interview on 5/8/2025 at 4:51 p.m. with the Director of Nursing (DON), the DON stated the facility did not reassess Resident 27 for self- administration of medications. The DON stated there was a risk for omission of medications and incorrect administration of medications by the resident. The DON stated the facility nurse was not supposed to document medications as administered when they were not administered to Resident 27. The DON stated the resident was at increased risk of glaucoma, eye irritation and dryness because the medications were not administered as prescribed. The DON stated Resident 27's metoprolol succinate ER 25 mg was administered late because it was administered at 9:00 a.m. instead of its scheduled administration time of 7:15 a.m. that should have been administered latest by 8:15 a.m. The DON stated Resident 27 would be at increased risk of high blood pressure resulting in heart complications and hospitalization. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4b. During a review of Resident 65's admission Record, dated 5/8/2025, the admission Record indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to muscle weakness, other specified abnormal findings of blood chemistry (measurement of various chemical substances in a blood sample) , dehydration (abnormally low fluid levels in the body) and alcohol abuse with intoxication (a state of acute impairment resulting from the consumption of substances such as drugs or alcohol) . During a review of Resident 65's MDS dated [DATE], the MDS indicated Resident 65 had severely impaired cognition. The MDS indicated that Resident 65 needed cleaning assistance from facility staff for ADLs such as eating, moderate assistance for oral hygiene, maximal assistance for upper body dressing and depending on the facility staff for toileting hygiene, showering, lower body dressing, putting on or taking off footwear and personal hygiene. During a concurrent observation and interview on 5/8/2025 at 9:04 a.m. with LVN 2, LVN 2 prepared eleven medications to be administered to Resident 65 that included one table of vitamin B complex. LVN 2 stated Resident 65 usually refused to take medications except for diphenhydramine (a medication used to treat itching). Resident 65 refused to take all the medications except one tablet of diphenhydramine 25 mg, even after LVN 2 explained the risks and benefits of taking his medications. During a medication reconciliation review on 5/8/2025 at 12:15 p.m., Resident 65's Order Summary Report, dated 5/8/2025, was reviewed. The document indicated the following physician order and there was no order for vitamin B complex. Thiamin HCl oral tablet, give 1 tablet by mouth one time a day for supplement, order date 7/13/2024, start date 7/14/2024 During an interview on 5/8/2025 at 1:47 p.m. with LVN 2, LVN 2 stated she prepared vitamin B complex during medication pass on 5/8/2025. LVN 2 stated the physician order was supposed to be for thiamin (vitamin B-1), so vitamin B complex was incorrect. LVN 2 stated although vitamin B complex was not administered because Resident 65 refused medications, it was important to follow physician orders. LVN 2 stated it would not be safe to overmedicate the resident with vitamin B complex when Resident 65 was only supposed to receive thiamin. During an interview on 5/8/2025 at 4:28 p.m. with the DON, the DON stated facility prepared the medication incorrectly for Resident 65 because he was supposed to receive thiamin and not vitamin B complex. The DON stated Resident 65 would not receive the benefits and effects from thiamin because of this error. 5. During a review of Resident 9's admission Record, dated 5/8/2025, the admission Record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (nerve damage due to diabetes) and other benign neoplasm of skin of right ear and external auricular canal (abnormal mass of tissue in external ear canal). (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 of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had moderately impaired cognition. The MDS indicated that Resident 9 needed cleaning assistance from facility staff for ADLs such as eating, supervision assistance for oral hygiene, moderate assistance for upper body dressing, maximal assistance for toileting, showering, lower body dressing and personal hygiene, and dependent on facility staff for putting on or taking off footwear. During a review of Resident 9's Order Summary Report, dated 5/8/2025, the Order Summary Report indicated, but not limited to the following physician order: Ciprofloxacin-dexamethasone otic (ear) suspension 0.3%-0.1%, instill four drops in right ear two times a day for ear infection for 7 days, order date 5/5/2025, start date 5/6/2025, end date 5/13/2025 During an observation on 5/7/2025 between 10:35 a.m. and 10:50 a.m. in Resident 9's room, LVN 2 prepared and administered ciprofloxacin 0.3% with dexamethasone 0.1% ear suspension for Resident 9. LVN 2 was not observed shaking the ear suspension prior to administration. LVN 2 told Resident 9 to keep her head and neck tilted to her left side while seated in wheelchair. LVN 2 instilled one drop of ciprofloxacin-dexamethasone into Resident 9's right ear. LVN 2 informed Resident 9 to keep her neck and head tilted in the same position for five minutes after which LVN 2 would resume to instill next drop. LVN 2 followed the same steps to instill four drops into Resident 9's right ear by waiting five minutes between each drop, taking a total of 20 minutes to complete medication administration. Resident 9 complained of her neck hurting throughout the process of receiving ciprofloxacin-dexamethasone ear drops. During an interview on 5/7/2025 at 11:10 a.m. with LVN 2, LVN 2 stated they were informed during a facility in-service to keep a five-minute interval between each drop instilled into the ears for adults. LVN 2 stated it took 20 minutes to administer Resident 9's ciprofloxacin with dexamethasone ear drops. LVN 2 stated she thought she had shaken the suspension before being observed for medication pass. LVN 2 stated it was important to shake the suspension for the medication to be effective for treatment of ear infection. During a concurrent interview and record review on 5/8/2025 at 4:28 p.m. with the DON, the facility's P&P titled, Specific Medication Administration Procedures - Ear Drop Administration, dated 05/2022, was reviewed. The P&P indicated, Procedures - F. Instill the prescribed number of drops into the ear canal. Do not touch including the ear. H. Instruct the resident to remain approximately 5 minutes with affected ear upward. The DON stated ciprofloxacin with dexamethasone ear drops should have been given as four drops and then wait five minutes to make sure the medication was administered into the ear. The DON stated the resident could get a stiff neck from keeping her neck tilted for a long time due to facility nurse's instructions to wait five minutes between each drop. The DON stated Resident 9 could get tired and might not want the medication administered next time could worsen the ear infection. 6a. During a review of Resident 9's Order Summary Report, dated 5/8/2025, the Order Summary Report indicated, but not limited to the following physician order: Pregabalin oral capsule 50 mg, give one capsule by mouth two times a day for diabetic neuropathy, order date 3/27/2025, start date 3/27/2025 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Palos Post-Acute Care Center	1430 West 6th Street San Pedro, CA 90732

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview and record review on 5/7/2025 at 4:43 p.m. with LVN 2 of Station 2 Medication Cart, Resident 9's medication card / bubble pack (a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles) , facility's controlled medication count sheet (CDR) and the medication administration details in electronic medical record (eMAR) for pregabalin 50 mg were reviewed. Resident 9's medication card / bubble pack for pregabalin 50 mg contained a quantity of 22 capsules remaining. The facility's CDR indicated a quantity of 23 capsules remaining with the last dose administered on 5/7/2025 at 9:00 a.m. The administration details in eMAR indicated the last dose of one capsule of pregabalin 50 mg for Resident 9 was documented as administered on 5/7/2025 at 4:16 p.m. LVN 2 stated she forgot to document in CDR after administering pregabalin 50 mg to Resident 9. LVN 2 stated she should have documented in CDR immediately after administering the medication to Resident 9 to ensure accuracy, and to prevent medication errors and controlled medication diversion. 6b. During a review of Resident 83's admission Record, dated 5/8/2025, the admission Record indicated Resident 83 was admitted to the facility on [DATE] with diagnoses including but not limited to epilepsy not intractable, without status epilepticus (controlled seizures [sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and not prolonged) and history of falling. During a review of Resident 83's MDS dated [DATE], the MDS indicated Resident 83 had moderately impaired cognition. The MDS indicated that Resident 83 needed supervision level assistance from the facility staff for eating and personal hygiene, moderate assistance for oral hygiene, upper body dressing, and maximal assistance for toileting, showering, lower body dressing and putting on or taking off footwear. During a review of Resident 83's order summary report, dated 5/8/2025, the document indicated, but not limited to the following physician order: Lacosamide oral tablet 50 mg, give 1 tablet by mouth two times a day for seizure, order date 2/19/2025, start date 2/20/2025 During a concurrent observation, interview and record review on 5/8/2025 at 10:32 a.m. with LVN 1 of Station 1 Medication Cart, Resident 83's medication card / bubble pack, facility's-controlled count sheet and the medication administration details in eMAR for lacosamide 50 mg were reviewed. Resident 83's medication card / bubble pack for lacosamide 50 mg contained a quantity of 23 tablets remaining. The facility's-controlled count sheet indicated a quantity of 24 tablets remaining with the last dose administered on 5/7/2025 at 5:00 p.m. The administration details in eMAR indicated the last dose of one tablet of lacosamide 50 mg for Resident 83 was documented as administered on 5/7/2025 at 5:24 p.m. LVN 1 stated he forgot to document in count sheet after administering lacosamide 50 mg to Resident 83. LVN 1 stated it was important to document on controlled count sheet after lacosamide was administered to ensure accuracy of medication administration, prevent medication errors and to prevent Resident 83 from having seizures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/2025 at 4:16 p.m. with the DON, the DON stated facility staff should sign in the controlled log count sheet and document in the eMAR as soon as a controlled medication was administered to a resident. The DON stated it was important for the controlled count sheet to match with what was administered because that would indicate medication was given and to prevent medication errors, drug diversion and loss. The DON stated there could be a risk of untreated pain for Resident 9 if pregabalin could not be accurately accounted for, and seizures for Resident 83 if she did not receive lacosamide. During a review of the facility's P&P titled, Preparation and General Guidelines, Medication Administration - General Guidelines, dated 05/2022, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with the written orders of the prescriber. Medications are administered within [60 minutes] of scheduled time . [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications .schedule for the facility. The P&P indicated, Documentation (including electronic) - The individual who administers the medication dose records the administration on the resident's MAR/eMAR directly after the medication is given. If electronic MAR is used, documentation of the unadministered dose is done as instructed .eMAR system .If [XX consecutive doses] of a vital medication are withheld, Or not available the physician is notified. During a review of the facility's P&P titled, Specific Medication Administration Procedures - Ear Drop Administration, dated 05/2022, the P&P indicated, Procedures - F. Instill the prescribed number of drops into the ear canal. Do not touch including the ear. H. Instruct the resident to remain approximately 5 minutes with affected ear upward. Gently place if necessary. During a review of the facility's P&P titled, Self-Administration of Medications, dated 02/2021, the P&P indicated, If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The P&P indicated, Any medications found at the bedside that are not authorized for self- administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility's P&P titled, Controlled Substances, dated 11/2022, the P&P indicated, The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records pharmacy records.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for two of seven sampled residents (Residents 27 and 65). The facility failed to: a. Administer Resident 27's metoprolol succinate (a medication used to treat hypertension [high blood pressure] and heart conditions) extended release (ER) within 60 minutes of its scheduled time as per facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 05/2022, and 2.Administer Resident 27's timolol ophthalmic solution (a medication used to treat glaucoma [progressive eye disease that damages optic nerve potentially leading to vision loss and blindness] and high eye pressure]), Alphagan P ophthalmic solution ([generic name - brimonidine] a medication used to treat glaucoma and high eye pressure), dorzolamide hydrochloride ophthalmic solution (a medication used to treat glaucoma and high eye pressure) and artificial tears eye solution (eye drops used to treat dry eyes). 3.Administer Resident 65's vitamin B-1 ([also known as thiamin] a vitamin used to treat low levels of vitamin B-1) in accordance with physician's orders. These deficient practices of medication administration error rate of 18.75 percent (%) exceeded the five (5) % threshold. Findings: a. During a review of Resident 27's admission Record (a document containing demographic and diagnostic information), dated 5/8/2025, the admission record indicated, Resident 27 was originally admitted to facility on 2/28/2014 and readmitted on [DATE] with diagnoses including but not limited to primary osteoarthritis, right and left shoulder, essential (primary) hypertension, pain syndrome, retinal edema (fluid buildup in areas of the eye) and unspecified glaucoma. During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool) dated 3/29/2025, the MDS indicated, Resident 27 had intact cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated, Resident 27 was independent with eating, needed setup assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, supervision assistance for toileting hygiene, upper body dressing, putting on/taking off footwear and personal hygiene, and needed moderate assistance for showering and lower body dressing. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/7/2025 at 8:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared eight medications to be administered to Resident 27 that did not include any eye drops. LVN 1 stated Resident 27's blood pressure was checked on 5/7/2025 at 8:50 a.m. which was recorded at systolic blood pressure ([SBP] the pressure caused by heart while contracting) of 136 millimeters of mercury (mmHg - a measurement of pressure) and diastolic blood pressure ([DBP] the pressure in the arteries when the heart rests between beats) of 70 mmHg, heart rate at 80 beats per minute and resident's pain was at 7 out of 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) at 8:50 a.m. LVN 1 prepared the following eight medications to be administered to Resident 27: 1. One tablet of gabapentin (a medication used to treat nerve pain) 600 milligrams ([mg] a unit of measurement for mass) 2. One capsule of duloxetine (a medication used to treat nerve pain) 60 mg 3. One tablet of metoprolol succinate ER 25 mg 4. One tablet of amlodipine (a medication used to treat high blood pressure) 5 mg 5. One tablet of meloxicam (a medication used to treat pain and inflammation) 7.5 mg 6. Two capsules of omega-3 (Docosahexaenoic Acid [DHA] and Eicosapentaenoic Acid [EPA] a medication used to treat high triglycerides [a type of fat that can negatively affect heart health]) 500 mg 7. Five tablets of vitamin D (a vitamin used to treat low levels of vitamin D) 25 micrograms (mcg - a unit of measurement for mass) 8. One tablet of famotidine (a medication used to treat stomach acid) 20 mg During a medication reconciliation review on 5/7/2025 at 12:20 p.m., Resident 27's Order Summary Report (a document containing a summary of all active physician orders), dated 5/1/2025, 5/8/2025 and order details were reviewed. The order summary report indicated, but not limited to the following physician order scheduled to be administered daily at 7:15 a.m.: Metoprolol Succinate ER Tablet ER 24 hour 25 milligrams (mg - a unit of measurement for mass), give 1 tablet by mouth two times a day for hypertension. Hold if SBP less than 100 or pulse rate (PR) less than 60 beats/minute give with meals (breakfast and dinner), order date 3/21/2025, start date 3/21/2025 The order summary report indicated Resident 27 also had the following medications scheduled to be administered daily at 9:00 a.m. Alphagan P Ophthalmic Solution 0.1% (Brimonidine tartrate), instill 1 drop in both eyes three times a day for glaucoma. Wait 5 minutes between administration of all other eye drops, order date 3/21/2025, start date 3/21/2025 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dorzolamide hydrochloride (HCl) solution 2%, instill 1 drop in both eyes two times a day for glaucoma supervised self-administration **wait 5 minutes between administration of all other eye drops, order date 3/21/2025, start date 3/21/2025 Timolol maleate ophthalmic solution 0.5%, instill 1 drop in both eyes two times a day for glaucoma. Wait at least 10 minutes before applying another eye medication, order date 4/20/2025, start date 4/21/2025 Artificial Tears Solution 1% (carboxymethylcellulose sodium), instill 2 drops in both eyes two times a day for dry eye syndrome. Wait at least 5 minutes before applying another eye medication, order date 3/21/2025, start date 3/21/2025 During a concurrent interview and record review on 5/7/2025 at 1:54 p.m. with RN Supervisor (RNS) 1, the order details and medication administration details of Resident 27's metoprolol succinate ER 25 mg were reviewed. RNS 1 stated Resident 27's metoprolol succinate ER 25 mg was administered more than 60 minutes after its scheduled administration time, so it would be considered late administration. RNS 1 stated Licensed Vocational Nurse (LVN) 1 should have administered the medication on 5/7/2025 by 8:15 a.m. because it was scheduled to be administered on 5/7/2025 at 7:15 a.m., but it was administered by LVN 1 at 9:00 a.m. RNS 1 stated Resident 27's blood pressure would not be managed well, increasing the risk for high blood pressure, stroke (loss of blood flow to a part of the brain) headache, nausea and vomiting. During a review of Resident 27's administration history for metoprolol succinate ER 25 mg, dated 4/23/2025 to 5/7/2025, the document indicated metoprolol succinate ER 25 mg was not administered within 60 minutes of scheduled time of 7:15 am for 10 times. During a concurrent interview and record review on 5/7/2025 at 2:06 p.m. with LVN 1, Resident 27's administration details for Alphagan P 0.1% ophthalmic solution, dorzolamide 2% ophthalmic solution, timolol 0.5% ophthalmic solution and artificial tears 1% solution and self-administration assessment were reviewed. The document indicated dorzolamide was documented as administered on 5/7/2025 at 8:54 a.m., timolol was documented as administered on 5/7/2025 at 8:55 a.m., Alphagan P was documented as administered on 5/7/2025 at 9:00 a.m. and 12:31 p.m., artificial tears were documented as administered on 5/7/2025 at 9:01 a.m. The review of Resident 27's self-administration assessment document, dated 3/29/2025, indicated Resident 27 was unable to self-administer medications. The document indicated physician order that indicated, Resident may not self-administer medications, medications given by licensed nurse on duty. At first, LVN 1 stated he administered the eye drops at or around 9:00 a.m., then stated he did not administer them. LVN 1 stated Resident 27 self-administered eye medications that included Alphagan P, timolol, dorzolamide and artificial tears. LVN 1 then reviewed the self-administration assessment document and stated Resident 27 was not supposed to keep any medications with her or self-administer medications because she was assessed to be unable to self-administer medications. LVN 1 stated the medications that were supposed to be self-administered would be given to the resident at the time of administration, but LVN 1 did not have those eye drops for Resident 27 in his medication cart, because the resident kept them at bedside. LVN 1 stated he did not remember when the last time he observed Resident 27 administering eye drops to herself. LVN 1 stated he was not supposed to document the medications as administered when they were not administered, and this would be considered as falsification of medical records. LVN 1 stated by missing her eye medications, Resident 27 was at risk for eye complications, worsening of glaucoma and disease progression. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/7/2025 at 3:05 p.m. with LVN 1 in Resident 27's room, dorzolamide 2% eye drops, brimonidine (Alphagan P) 0.1% and Lumigan 0.01% ([generic name - bimatoprost] a medication used to treat glaucoma and high eye pressure) were found at resident's bedside. LVN 1 stated he would remove the medications from Resident 27's bedside because there was a risk for unsafe and incorrect administration of eye drops by the resident because the facility's assessment for self-administration indicated that Resident 27 was unable to self-administer. LVN 1 stated he did not have timolol and artificial tears in stock and would need to reorder all of Resident 27's eye drops from the pharmacy. During an interview on 5/8/2025 at 4:51 p.m. with the Director of Nursing (DON), the DON stated the facility did not reassess Resident 27 for self- administration of medications. DON stated there was a risk for omission of medications and incorrect administration of medications by the resident. The DON stated facility nurse was not supposed to document medications as administered when they were not administered to the resident. The DON stated the resident was at increased risk of glaucoma, eye irritation and dryness because the medications were not administered as prescribed. The DON stated Resident 27's metoprolol succinate ER 25 mg was administered late because it was administered at 9:00 a.m. instead of its scheduled administration time of 7:15 a.m. that should have been administered latest by 8:15 a.m. The DON stated Resident 27 would be at increased risk of high blood pressure resulting in heart complications and hospitalization. b. During a review of Resident 65's admission Record, dated 5/8/2025, the admission Record indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to muscle weakness, other specified abnormal findings of blood chemistry (measurement of various chemical substances in a blood sample) , dehydration (abnormally low fluid levels in the body) and alcohol abuse with intoxication (a state of acute impairment resulting from the consumption of substances such as drugs or alcohol) . During a review of Resident 65's MDS dated [DATE], the MDS indicated Resident 65 had severely impaired cognition. The MDS indicated, Resident 65 needed cleaning assistance from facility staff for ADLs such as eating, moderate assistance for oral hygiene, maximal assistance for upper body dressing and depending on the facility staff for toileting hygiene, showering, lower body dressing, putting on or taking off footwear and personal hygiene. During a concurrent observation and interview on 5/8/2025 at 9:04 a.m. with LVN 2, LVN 2 prepared eleven medications to be administered to Resident 65 that included one table of vitamin B complex. LVN 2 stated Resident 65 usually refused to take medications except for diphenhydramine (a medication used to treat itching). Resident 65 refused to take all the medications except one tablet of diphenhydramine 25 mg, even after LVN 2 explained the risks and benefits of taking his medications. During a medication reconciliation review on 5/8/2025 at 12:15 p.m., Resident 65's Order Summary Report, dated 5/8/2025, was reviewed. The document indicated the following physician order and there was no order for vitamin B complex. Thiamin HCl oral tablet, give 1 tablet by mouth one time a day for supplement, order date 7/13/2024, start date 7/14/2024 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/2025 at 1:47 p.m. with LVN 2, LVN 2 stated she prepared vitamin B complex during medication pass on 5/8/2025. LVN 2 stated the physician order was supposed to be for thiamin (vitamin B-1), so vitamin B complex was incorrect. LVN 2 stated although vitamin B complex was not administered because Resident 65 refused medications, it was important to follow physician orders. LVN 2 stated it would not be safe to overmedicate the resident with vitamin B complex when Resident 65 was only supposed to receive thiamin. During an interview on 5/8/2025 at 4:28 p.m. with the DON, The DON stated facility prepared the medication incorrectly for Resident 65 because he was supposed to receive thiamin and not vitamin B complex. The DON stated Resident 65 would not receive the benefits and effects from thiamin because of this error. During a review of the facility's P&P titled, Preparation and General Guidelines, Medication Administration - General Guidelines, dated 05/2022, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with the written orders of the prescriber. Medications are administered within [60 minutes] of scheduled time . [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications .schedule for the facility. During a review of the facility's P&P titled, Self-Administration of Medications, dated 02/2021, the P&P indicated, If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The P&P indicated, Any medications found at the bedside that are not authorized for self- administration are turned over to the nurse in charge for return to the family or responsible party.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for one (Resident 27) of seven sampled residents during medication administration. The facility failed to: 1. Administer Resident 27's metoprolol succinate (a medication used to treat hypertension [high blood pressure] and heart conditions) extended release (ER) within 60 minutes of its scheduled time of administration as per facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 05/2022. This deficient practice failed to provide medication in accordance with the physician's orders or professional standards of practice and had the potential to result in hypertension, stroke (loss of blood flow to a part of the brain) and hospitalization for Resident 27. Findings: During a review of Resident 27's admission Record (a document containing demographic and diagnostic information), dated 5/8/2025, the admission record indicated, Resident 27 was originally admitted to facility on 2/28/2014 and readmitted on [DATE] with diagnoses including but not limited to primary osteoarthritis, right and left shoulder, essential (primary) hypertension, pain syndrome, retinal edema (fluid buildup in areas of the eye) and unspecified glaucoma. During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool) dated 3/29/2025, the MDS indicated, Resident 27 had intact cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated, Resident 27 was independent with eating, needed setup assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, supervision assistance for toileting hygiene, upper body dressing, putting on/taking off footwear and personal hygiene, and needed moderate assistance for showering and lower body dressing. During a concurrent observation and interview on 5/7/2025 at 8:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared eight medications to be administered to Resident 27 that that included one tablet of metoprolol succinate ER 25 mg with instructions to hold for systolic blood pressure ([SBP] the pressure caused by heart while contracting) less than 100 and for pulse rate (PR) less than 60. LVN 1 stated Resident 27's blood pressure was checked on 5/7/2025 at 8:50 a.m. which was recorded at systolic blood pressure ([SBP] the pressure caused by heart while contracting) of 136 millimeters of mercury (mmHg - a measurement of pressure) and diastolic blood pressure ([DBP] the pressure in the arteries when the heart rests between beats) of 70 mmHg, heart rate at 80 beats per minute and resident's pain was at 7 out of 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) at 8:50 a.m. During a medication reconciliation review on 5/7/2025 at 12:20 p.m., Resident 27's Order Summary Report (a document containing a summary of all active physician orders), dated 5/1/2025, 5/8/2025 and order details were reviewed. (continued on next page)

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	055527	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Palos Post-Acute Care Center	1430 West 6th Street San Pedro, CA 90732

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The order summary report indicated, but not limited to the following physician order scheduled to be administered at 7:15 a.m.: Metoprolol Succinate ER Tablet ER 24 hour 25 milligrams (mg - a unit of measurement for mass), give 1 tablet by mouth two times a day for hypertension, hold if SBP less than 100 or pulse rate (PR) less than 60, give with meals (breakfast and dinner), order date 3/21/2025, start date 3/21/2025 During a concurrent interview and record review on 5/7/2025 at 1:54 p.m. with RN Supervisor (RNS) 1, the order details and medication administration details of Resident 27's metoprolol succinate ER 25 mg were reviewed. RNS 1 stated Resident 27's metoprolol succinate ER 25 mg was administered more than 60 minutes after its scheduled administration time, so it would be considered late administration. RNS 1 stated Licensed Vocational Nurse (LVN) 1 should have administered the medication on 5/7/2025 by 8:15 a.m. because it was scheduled to be administered on 5/7/2025 at 7:15 a.m., but it was administered by LVN 1 at 9 a.m. RNS 1 stated Resident 27's blood pressure would not be managed well, increasing the risk for high blood pressure, stroke (loss of blood flow to a part of the brain) headache, nausea and vomiting. During a review of Resident 27's administration history for metoprolol succinate ER 25 mg, dated 4/23/2025 to 5/7/2025, the document indicated metoprolol succinate ER 25 mg was administered late 10 times, which was beyond 60 minutes of its scheduled time of administration. During an interview on 5/8/2025 at 4:51 p.m. with the Director of Nursing (DON), the DON stated Resident 27's metoprolol succinate ER 25 mg was administered late because it was administered at 9:00 a.m. instead of its scheduled administration time of 7:15 a.m. that should have been administered latest by 8:15 a.m. The DON stated Resident 27 would be at increased risk of high blood pressure resulting in heart complications and hospitalization. During a review of the facility's P&P titled, Preparation and General Guidelines, Medication Administration - General Guidelines, dated 05/2022, the P&P indicated, Medications are administered in accordance with the written orders of the prescriber. Medications are administered within [60 minutes] of scheduled time . [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications .schedule for the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure the dose on Resident 59's Lantus Solostar's ([generic name - insulin glargine] a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] used to treat high blood sugar) pharmacy label matched with the physician order in electronic medical health record (eMHR), and was labeled with an open date in accordance with manufacturer specifications, and as per facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, affecting one of seven sampled residents during medication administration. 2. Ensure removal of Resident 25's discontinued Humalog ([generic name - insulin lispro] a type of insulin used to treat high blood sugar) vial from Station 1 Medication Room Refrigerator, affecting one of one medication rooms inspected (Station 1 Medication Room). 3. Ensure Resident 27's medications including dorzolamide (a medication used to treat glaucoma [progressive eye disease that damages optic nerve potentially leading to vision loss and blindness] and high eye pressure]) eye drops, brimonidine (a medication used to treat glaucoma and high eye pressure) eye drops and Lumigan ([generic name - bimatoprost] a medication used to treat glaucoma and high eye pressure) eye drops were stored securely in medication cart and not at resident's bedside, affecting one (Resident 27) of seven sampled residents during medication administration. 4. Ensure removal of three containers of expired Naloxone Nasal Spray (a medication used to reverse opioid [a category of controlled medications - medications that the use and possession of are controlled by the federal government, used to manage pain] overdose) from the medication cart, affecting two residents (Residents 32 and 40) in one of two medication carts inspected (Middle Medication Cart). These deficient practices had the potential to result in Residents 25, 27, 32, 40 and 59 receiving medications that were discontinued, had become expired, ineffective, or toxic due to improper storage and labeling possibly leading to accidental administration and other adverse events such as abnormal blood glucose levels, eye complications, opioid overdose (a class of drug used to reduce moderate to severe pai) , hospitalization and death. Findings: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a concurrent observation and interview on [DATE] at 9:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 checked Resident 59's blood glucose and stated it was 170 milligrams (mg - a unit of measurement for mass) per deciliter (dL - a unit of measurement for volume). LVN 1 stated the opened Lantus Solostar pen in his medication cart did not have sufficient dose to be administered to Resident 59. LVN 1 then went to the medication room and removed one unopened Lantus Solostar 100 units (a unit of measurement for insulin) per milliliter ([mL] a unit of measurement for volume) pen from Station 1 medication refrigerator to be administered to Resident 59. The pharmacy label for Resident 59's Lantus Solostar pen indicated dosing instructions as Inject 14 units subcutaneously every 12 hours for type 2 DM rotate injection site. LVN 1 stated the dose should be Inject 16 units (not 14 units) subcutaneously every 12 hours which was the updated physician's order in eMAR, but pharmacy labels were not updated to match the physician order. LVN 1 stated the order was updated on [DATE]. LVN 1 administered insulin dose to Resident 59 from Lantus Solostar pen on [DATE] at 10:14 a.m. LVN 1 did not place an open date on the Lantus Solostar pen after opening and placed it in the medication cart. When surveyor asked LVN 1 about the process for insulin labeling, LVN 1 stated he forgot to place an open date on Resident 59's Lantus Solostar pen. LVN 1 stated it was important to indicate the open date to be able to determine expiration date after insulin was taken out of the refrigerator. According to the manufacturer's product labeling, unopened / not in-use Lantus Solostar pen if stored at room temperature (below 86-degree Fahrenheit [(°F) is a unit of temperature]) [30-degree Celsius [(°C) is a unit of temperature]) and opened / in-use Lantus Solostar pen must be used within 28 days. During an interview on [DATE] at 4:42 p.m. with the Director of Nursing (DON), the DON stated facility would need to check with the pharmacy of their process for when Resident 59's Lantus Solostar pharmacy label indicated different dose than physician order in eMHR. The DON stated there would be a risk of medication errors because the pharmacy label indicated a different dose than eMHR. The DON stated Lantus Solostar is an insulin and once it was removed from the refrigerator, the facility nurse should have placed an open date to determine expiration date, ensure its potency for it to be safe and effective use to manage resident's blood glucose levels. 2. During a concurrent observation and interview on [DATE] at 9:56 a.m. with Registered Nurse Supervisor (RNS) 1 in Station 1 Medication Room, the medication refrigerator contained the following medication: a. One sealed vial of Humalog 100 units/mL, quantity of 10 mL for Resident 25 with date of [DATE]. RNS 1 stated Humalog for Resident 25 was discontinued on [DATE]. RNS 1 stated the medication should have been discarded after it was discontinued. RNS 1 stated Humalog for Resident 25 should have been removed from the refrigerator to prevent accidental administration and medication errors. During a review of Resident 25's order details, dated [DATE], the document indicated Humalog injection solution 100 units/mL (Insulin Lispro) inject as per sliding scale with sliding scale instructions with discontinued date as [DATE] at 6:17 p.m. and discontinue reason as start on metformin by mouth (PO). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:12 p.m. with the DON, the DON stated it was important to remove Humalog from the medication refrigerator after it was discontinued. The DON stated having discontinued medication in current stock had the potential to result in its accidental use, increasing the risk for medication errors and adverse effects such as hypoglycemia (low blood sugar levels) for Resident 25. 3. During a concurrent observation and interview on [DATE] at 3:05 p.m. in Resident 27's room with LVN 1, dorzolamide 2% eye drops, brimonidine (Alphagan P) 0.1% and Lumigan 0.01% ([generic name - bimatoprost] a medication used to treat glaucoma and high eye pressure) were found at resident's bedside. LVN 1 stated he would remove the medications from Resident 27's bedside because there was a risk for unsafe and incorrect administration of eye drops by the resident because the facility's assessment for self-administration indicated that Resident 27 was unable to self-administer. During an interview on [DATE] at 4:51 p.m. with the Director of Nursing (DON), the DON stated the facility did not reassess Resident 27 for self- administration of medications. The DON stated there was a risk for omission of medications and incorrect administration of medications by the resident. 4. During a concurrent observation and interview on [DATE] at 1:02 p.m. with LVN 4 of the Middle Medication Cart, the following medications were found expired and stored in a manner contrary to the manufacturer's requirements: 4a. Two sealed containers of Naloxone hydrochloride (HCl) Nasal Spray for Resident 32 with an expiration date of 12/2024 4b. One sealed container of Naloxone HCl Nasal Spray for Resident 40 with an expiration date of 4/2025 According to the manufacturer's product labeling, naloxone Nasal Spray should be replaced before its expiration date. LVN 4 stated naloxone was the medication to be used to treat opioid overdose. LVN 4 stated the naloxone sprays were expired so they would not be safe or effective to treat opioid overdose for the residents. LVN 4 stated the expired naloxone nasal sprays should have been discarded. LVN 4 stated untreated opioid overdose could also lead to death. During an interview on [DATE] at 4:23 p.m. with the DON, the DON stated the expired naloxone should have been removed from the medication cart. The DON stated the expired naloxone nasal spray would not be safe or effective to administer to the residents. The DON stated there was a possibility that the expired naloxone would not work in a life-threatening situation to treat an opioid overdose and could risk resident's lives. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated 04/2019, the P&P indicated, When opening a multi-dose container, the date opened is recorded on the container. The P&P indicated, Residents may self-administer their own medication only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated, if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. The P&P indicated, Labeling of medications and biologicals consistent with applicable federal and state requirements and currently accepted .practices. The medication label includes, at a minimum, a. medication name (generic and/or brand) .d. expiration date, when applicable. The P&P indicated, the nursing staff must inform the pharmacy of any changes in physician orders for a medication. During a review of the facility's P&P titled, Discontinued Medications, dated 4/2007, the P&P indicated, The nurse receiving the order to discontinue a medication is responsible for recording the information and notifying the dispensing pharmacy of the discontinuation. Discontinued medications must be destroyed or returned .with established policies.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record the facility failed to ensure one of one sampled resident (Resident 85), food likes, and cultural preferences were met and honored. This failure resulted in Resident 85's not receiving food items from Resident 85's choice and preference. Findings: During a review of Resident 85's admission Record (Face Sheet), the Face Sheet indicated Resident 85 was admitted to the facility on [DATE] with diagnoses of but not limited to Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), low back pain, muscle weakness and dementia(a progressive state of decline in mental abilities). During a review of Resident 85's History and Physical (H&P), dated 4/3/2025, the H&P indicated, Resident 85 did not have the capacity to make decisions. The H&P indicated Resident 85 was alert to his name only. During a review of Resident 85's Minimum Data Set (MDS-), dated 3/31/2025, the MDS indicated Resident 85 usually had the ability to express wants and ideas. The MDS indicated Resident 85 had the usually had the ability to understand others. The MDS indicated Resident 85 needed substantial to maximal assistance with eating, oral hygiene, toileting, showering and dressing. During a review of Resident 85's Physician Orders, dated 3/27/2025, the Physician Orders indicated, Resident 85 had an order for a no added salt diet regular texture and regular liquid consistency. During a review of Resident 85's Physician Orders, dated 4/1/2025, the Physician Orders indicated, Resident 85 had an order to add malnutrition (lack of proper nutrition) to his diagnosis. During a review of Resident 85's Care Plan, dated 4/1/2025, the Care Plan indicated a goal for Resident 85 was to have Resident 85 state his food preferences to include them in his therapeutic diet. During an interview on 5/7/2025 with Resident 85's Family Member (FM) 3, FM 3 stated Resident 85 speaks Japanese and can only speak a little English. The Representative stated Resident 85 was unable to express himself verbally. The representative stated no staff at the facility speaks Japanese. During an interview on 5/8/2025 at 10:24 AM with Certified Nurse Assistant (CNA) 5, CNA 5 stated Resident 85 never gets Japanese food. CNA 5 stated Resident 85 would probably like Japanese food because of his culture. During an interview on 5/08/2025 at 1:19 PM with the [NAME] (Cook 1), COOK 1 stated based on Resident 85 meal ticket upon admission, Resident 85 likes everything does not have any dislikes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/08/2025 at 1:57 PM with the Dietary Staff Supervisor (DSS), the DSS stated upon admission to the facility her responsibilities are to interview the residents for food preferences, likes and dislikes. The DSS stated she interviewed Resident 85 on 3/31/2025 and did not have any dislikes. The DSS stated she did not speak to Resident 85 family or Representative about cultural food preferences, likes, or dislikes. The DSS stated Resident 85 has a BIMS score of three (indicates a severe level of cognitive impairment) she should have interviewed the family about likes, dislikes, and cultural food preferences. The DSS stated she does not know what language Resident 85 speaks or what his culture is. The DSS stated Resident 85 could have weight loss if his food likes, dislikes and cultural food preferences are not provided. During an interview on 5/9/2025 at 4:42 PM with the Director of Nursing (DON), the DON stated Resident 85 could be socially isolated, will not like the food served and could have weight loss. During a review of the facility's policy and procedure (P&P) for the dietary service supervisor titled, Orientation, Inservice, and Personnel Management Job Description, dated 2012, the P&P indicated the dietary service supervisor Participates in charting responsibilities (MDS, care plans, quarterly reviews, resident/patient visits, food preference updates) as requested by facility and Registered Dietitian.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure three of three sampled residents (Resident 82, Resident 48, and Resident 41) was served food that was appetizing, not bland and tasteless. This failure had the potential for Resident 82, Resident 48, and Resident 41) to lose weight. Findings: During a review of Resident 82's admission Record (Face Sheet), the Face Sheet indicated Resident 82 was admitted to facility on 12/28/2024 with diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension(HTN-high blood pressure) and hyperlipidemia(elevated levels of cholesterol). During a review of Resident 82's Minimum Data Set (MDS-), dated 1/6/2025, the MDS indicated, Resident 82 had the ability to understand others. The MDS indicated Resident 82 had the ability to express ideas and wants. During a review of Resident 82's Physician Orders, dated 12/28/2024, the Physician Orders indicated, Resident 82 had an order for a two-gram sodium diet with regular texture and regular liquid consistency. During a review of Resident 82's Interdisciplinary Team(a group of professional from different disciplines or fields who work together towards a common goal)-Plan of Care Meeting, dated 12/28/2024, the Interdisciplinary Team-Plan of Care Meeting indicated, Resident 82 had variable food intake possible due to intolerance to prescribed diet. During a review of Resident 82's Nutritional/Dietary Note, dated 3/23/2025, indicated Resident 82's wife brings food due to episodes of Resident 82 not liking the meals given to him. During a review of Resident 48's admission Record (Face Sheet), the Face Sheet indicated Resident 48 was admitted to facility on 9/2/2024 with diagnoses of dysphagia(difficulty swallowing), diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia(elevated levels of cholesterol). During a review Resident 48's Minimum Data Set (MDS-), dated 9/14/2024, the MDS indicated, Resident 48 had the ability to understand others. The MDS indicated Resident 82 had the ability to express ideas and wants. During a review of Resident 48's Physician Orders, dated 12/17/2024, the Physician Orders indicated, Resident 48 had an order for a no added salt consistent carbohydrate diet with mechanical soft texture and regular liquid consistency. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41's admission Record (Face Sheet), the Face Sheet indicated, Resident 41 was originally admitted to the facility on [DATE]. The Face Sheet indicated Resident 41 was readmitted to the facility on [DATE] with diagnoses of but not limited to diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (the kidneys are damaged and cannot filter blood properly), and spinal stenosis (the bony tunnel that surrounds the spinal cord and nerve roots, become narrowed). During a review of Resident 41's Minimum Data Set (MDS-), dated 2/11/2025, the MDS indicated Resident 41 had the ability to understand and the ability to express ideas and wants. The MDS indicated Resident 41 had the ability to understand others with clear comprehension. During a review of Resident 41's Physician Orders, dated 1/22/2025, the Physician Orders indicated, Resident 41 had an order for a regular diet with regular texture and regular liquid consistency . During an interview on 5/6/2025 at 2:06 PM, with Resident 82, Resident 82 stated the food is horrible and always cold. Resident 82 stated he buys his own groceries. During an interview on 5/7/2025 at 9:51 AM with Resident 48, Resident 48 stated the food is awful. During an interview on 5/7/2025 at 12:23 PM with Resident 41, Resident 41 stated the food is awful, it has no taste, and no flavor. Resident 41 stated she keeps her own salt and pepper at bedside. Resident 41 stated breakfast is boring. Resident 41 stated the facility serves the same thing every day. Resident 41 stated the eggs not edible and cold. During a concurrent observation and interview on 5/8/2025 at 1:30 pm with the [NAME] (Cook) 1, a regular diet test tray was requested for flavor. The test tray included pork, carrots, and polenta. The carrots were pale grayish orange in color. The meat was greasy. The polenta was tasteless. The food was unseasoned, had no flavor and not pleasing or appetizing. [NAME] 1 stated the food is prepared and cooked at a nearby facility. The [NAME] 1 stated the food is brought into the facility in hot carts. The cook stated her responsibility is to check to make sure the food is correct before distributing the trays. During a review of the facility's policy and procedure (P&P) for the dietary service supervisor titled, Orientation, Inservice, and Personnel Management Job Description, dated 2012, the P&P indicated the dietary service supervisor Ensures residents/patients receive the proper food items to meet their dietary needs and that food is served at the appropriate temperature for safety and palatability.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed staff did not falsify medication administration record ([MAR] a record of all medications administered to a resident) entries as administered for medications listed below that were not available in facility, not administered or not observed as self-administered for one of seven sampled residents (Resident 27). For Resident 27, the facility nurses documented on the MAR for timolol ophthalmic solution (a medication used to treat glaucoma [progressive eye disease that damages optic nerve potentially leading to vision loss and blindness] and high eye pressure]), Alphagan P ophthalmic solution ([generic name - brimonidine] a medication used to treat glaucoma and high eye pressure), dorzolamide hydrochloride ophthalmic solution (a medication used to treat glaucoma and high eye pressure) and artificial tears eye solution (eye drops used to treat dry eyes) as administered for different scheduled times. This deficient practice of failing to ensure the medical records accurately reflect care delivered to the residents increased the risk that Resident 27 may not have received their medications as ordered possibly resulting in medical complications leading to an overall diminished quality of life. Findings: During a review of Resident 27's admission Record (a document containing demographic and diagnostic information), dated 5/8/2025, the admission record indicated, Resident 27 was originally admitted to facility on 2/28/2014 and readmitted on [DATE] with diagnoses including but not limited to primary osteoarthritis, right and left shoulder, essential (primary) hypertension, pain syndrome, retinal edema (fluid buildup in areas of the eye) and unspecified glaucoma. During a concurrent observation and interview on 5/7/2025 at 8:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared eight medications to be administered to Resident 27 that did not include any eye drops. LVN 1 stated Resident 27's blood pressure was checked on 5/7/2025 at 8:50 a.m. which was recorded at systolic blood pressure ([SBP] the pressure caused by heart while contracting) of 136 millimeters of mercury (mmHg - a measurement of pressure) and diastolic blood pressure ([DBP] the pressure in the arteries when the heart rests between beats) of 70 mmHg, heart rate at 80 beats per minute and resident's pain was at 7 out of 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) at 8:50 a.m. LVN 1 prepared the following eight medications to be administered to Resident 27: 1. One tablet of gabapentin (a medication used to treat nerve pain) 600 milligrams ([mg] a unit of measurement for mass) 2. One capsule of duloxetine (a medication used to treat nerve pain) 60 mg 3. One tablet of metoprolol succinate ER 25 mg 4. One tablet of amlodipine (a medication used to treat high blood pressure) 5 mg 5. One tablet of meloxicam (a medication used to treat pain and inflammation) 7.5 mg (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Two capsules of omega-3 (Docosahexaenoic Acid [DHA] and Eicosapentaenoic Acid [EPA] a medication used to treat high triglycerides [a type of fat that can negatively affect heart health]) 500 mg 7. Five tablets of vitamin D (a vitamin used to treat low levels of vitamin D) 25 micrograms (mcg - a unit of measurement for mass) 8. One tablet of famotidine (a medication used to treat stomach acid) 20 mg During a medication reconciliation review on 5/7/2025 at 12:20 p.m., Resident 27's Order Summary Report (a document containing a summary of all active physician orders), dated 5/8/2025, 5/1/2025 and order details were reviewed. The order summary report indicated Resident 27 also had the following medications scheduled to be administered daily at 9:00 a.m.: Alphagan P Ophthalmic Solution 0.1% (Brimonidine tartrate), instill 1 drop in both eyes three times a day for glaucoma. Wait 5 minutes between administration of all other eye drops, order date 3/21/2025, start date 3/21/2025 Dorzolamide hydrochloride (HCl) solution 2%, instill 1 drop in both eyes two times a day for glaucoma supervised self-administration **wait 5 minutes between administration of all other eye drops, order date 3/21/2025, start date 3/21/2025 Timolol maleate ophthalmic solution 0.5%, instill 1 drop in both eyes two times a day for glaucoma. Wait at least 10 minutes before applying another eye medication, order date 4/20/2025, start date 4/21/2025 Artificial Tears Solution 1% (carboxymethylcellulose sodium), instill 2 drops in both eyes two times a day for dry eye syndrome. Wait at least 5 minutes before applying another eye medication, order date 3/21/2025, start date 3/21/2025 During a concurrent interview and record review on 5/7/2025 at 2:06 p.m. with LVN 1, Resident 27's administration details for Alphagan P 0.1% ophthalmic solution, dorzolamide 2% ophthalmic solution, timolol 0.5% ophthalmic solution and artificial tears 1% solution for and self-administration assessment were reviewed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document indicated dorzolamide was documented as administered on 5/7/2025 at 8:54 a.m., timolol was documented as administered on 5/7/2025 at 8:55 a.m., Alphagan P was documented as administered on 5/7/2025 at 9:00 a.m. and 12:31 p.m., artificial tears were documented as administered on 5/7/2025 at 9:01 a. m. The review of Resident 27's self-administration assessment document, dated 3/29/2025, indicated Resident 27 was unable to self-administer medications. The document indicated physician order that indicated, Resident may not self-administer medications, medications given by licensed nurse on duty. At first, LVN 1 stated he administered the eye drops at or around 9:00 a.m., then stated he did not administer them. LVN 1 stated Resident 27 self-administered eye medications that included Alphagan P, timolol, dorzolamide and artificial tears. LVN 1 then reviewed the self-administration assessment document and stated Resident 27 was not supposed to keep any medications with her or self-administer medications because she was assessed to be unable to self-administer medications. LVN 1 stated the medications that were supposed to be self-administered would be given to the resident at the time of administration, but LVN 1 did not have those eye drops for Resident 27 in his medication cart, because the resident kept them at bedside. LVN 1 stated he did not remember when the last time he observed Resident 27 administering eye drops to herself. LVN 1 stated he was not supposed to document the medications as administered when they were not administered, and this would be considered as falsification of medical records. LVN 1 stated by missing her eye medications, Resident 27 was at risk for eye complications, worsening of glaucoma and disease progression. During a concurrent observation and interview on 5/7/2025 at 3:05 p.m. in Resident 27's room with LVN 1, dorzolamide 2% eye drops, brimonidine (Alphagan P) 0.1% and Lumigan 0.01% ([generic name - bimatoprost] a medication used to treat glaucoma and high eye pressure) were found at resident's bedside. LVN 1 stated he did not have timolol and artificial tears in stock and would need to reorder all of Resident 27's eye drops from the pharmacy. During an interview on 5/8/2025 at 4:51 p.m. with the Director of Nursing (DON), the DON stated the facility did not reassess Resident 27 for self- administration of medications. The DON stated there was a risk for omission of medications and incorrect administration of medications by the resident. The DON stated facility nurse was not supposed to document medications as administered when they were not administered to the resident. The DON stated the resident was at increased risk of glaucoma, eye irritation and dryness because the medications were not administered as prescribed. During a review of the facility's P&P titled, Preparation and General Guidelines, Medication Administration - General Guidelines, dated 05/2022, the P&P indicated, Documentation (including electronic) - The individual who administers the medication dose records the administration on the resident's MAR/eMAR directly after the medication is given. If electronic MAR is used, documentation of the unadministered dose is done as instructed .eMAR system .If [XX consecutive doses] of a vital medication are withheld, Or not available the physician is notified. The P&P indicated, Medications are administered in accordance with the written orders of the prescriber.

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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. Based on interview and record review the facility's Quality Assessment and Assurance (QAA committees established for the purpose of improving the safety and quality of health services) and Quality Assurance Performance Improvement (QAPI- approach to maintain and improve safety and quality in nursing homes) committee failed to implement corrective action to the potential systemic problems identified: 1.Maintain a system to ensure call lights are answered timely. 2.Maintain a system to ensure activities of daily living are implemented. 3.Maintain a system to ensure accurate pharmaceutical services and procedures. 4.Maintain a system to ensure accurate pharmaceutical services and procedures. 5.Maintain a system free of significant medication error. 6.Maintain a system to ensure the storage and labeling of biological and medications. 7.Maintain a system to ensure food is stored in a sanitary manor. 8.Maintain clinical records in accordance with accepted professional standards and practices. These deficient practices had the potential to result in the residents residing in the facility not receiving services and care they need. Findings: During an interview on 5/9/2025 at 5:05 PM with the Administrator (ADM), the ADM stated the facility is working on improvement of pressure ulcers, medication, and call lights. The ADM stated in-services and education are being done and is very important. DON stated everybody is responsible for identifying skin issues and answering call lights. DON stated there is a need for improvement and will be working on the issues identified as deficient practices. During a review of the facility's policy and procedures (P&P) titled, Quality Assurance Performance Improvement, revised dated 2/2020, the P&P indicated, The objectives of the QAPI Program are to provide a means to measures current and potential indicators for outcomes of care and quality of life. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. Establish systems through which to monitor and evaluate corrective actions.

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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. Based on observation, interview, and record review, the facility failed to implement and maintain infection control procedures when Licensed Vocational Nurse (LVN) 3 failed to perform hand hygiene between resident's care and prior to entering and exiting the resident room. This deficient practice had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and spread of diseases and infection to the facility staff, residents, and visitors. Findings: During an observation on 5/8/2025 at 11:04 a.m., LVN 3 was observed not performing hand hygiene between resident care or when entering and exiting a resident room. During an interview on 5/8/2025 at 11:12 a.m., LVN 3 stated she should have performed hand hygiene to prevent the spread of germs and infection. During an interview on 5/9/2025 at 1:38 p.m., with the Director of Nursing (DON), the DON stated the number one way to prevent the spread of infection was through hand hygiene. The DON stated the staff should perform hand hygiene between resident care and when entering and exiting a resident room. The DON stated not performing hand hygiene can lead to a resident developing an infection or spreading infection to others. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 8/2019, the P&P indicated, The facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their protocol for Antibiotic Stewardship (refers to a set of commitments actions designed to optimize the treatments of infections while reducing the adverse events associated with antibiotic use) for one of three sampled residents (Resident 78) by prescribing an antibiotic medication (a substance used to kill bacteria and treat infections) without meeting the criteria, before being treated for toe cellulitis (a skin infection that causes swelling and redness). This failure had the potential for Resident 78 to develop antibiotic resistance (not effective to treat infection) from inappropriate antibiotic use. Findings: During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 78's Minimum Data Set (MDS- a resident assessment tool) dated 2/28/2025, the MDS indicated Resident 78's cognition (ability to think, understand, learn, and remember) was severely impaired and required supervision with toileting and dressing. During a review of Resident 78's Order Summary Report, the Order Summary Report indicated an order was placed 5/6/2025 for Doxycycline Hyclate (medication to treat an infection) for left second toe cellulitis (a skin infection that causes swelling and redness). During a concurrent interview and record review on 5/7/2025 at 12:18 p.m., with the Infection Prevention Nurse (IPN), the IPN stated on 5/6/2025 Resident 78 was prescribed Doxycycline 100 milligrams (mg- unit of measurement) twice a day for seven days for left toe cellulitis. IPN stated a wound culture should be done for any wound drainage. IPN stated a wound culture should have been collected prior to starting the antibiotic to ensure the correct bacteria was being treated because the resident could develop an adverse reaction or antibiotic resistance (when bacteria change to resist antibiotics that are used to effectively treat them). The IPN stated Resident 78 did not meet the McGreer's Criteria (a set of guidelines for identifying infections in long-term care facilities) and not doing so could cause harm to Resident 78. During an interview on 5/9/2025 at 1:38 p.m., with the Director of Nursing (DON), the DON stated the facility uses the McGreer's Criteria to ensure the correct antibiotic was ordered for the specific organism. The DON stated not following the McGreer's Criteria could cause a delay in healing or the development of resistance to the antibiotic. The DON stated a wound culture should be obtained to ensure the correct antibiotic was ordered. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship- Order for Antibiotics, dated 12/2016, the P&P indicated, Appropriate indications for use of antibiotics include: criteria met for clinical definition of active infection or suspected sepsis; Pathogen susceptibility, based on culture and sensitivity. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Antibiotic Stewardship, dated 12/2016, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed to ensure one of the sampled residents (Resident 82) was provided with a home-like environment, Resident 82 had a large hole in his sliding screen door. This failure had the potential to have unwanted pest entering Resident 82's room . Findings: During a review of Resident 82's admission Record (Face Sheet), the admission Record indicated Resident 82 was admitted to facility on 12/28/2024 with diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension(HTN-high blood pressure) and hyperlipidemia (elevated levels of cholesterol). During a review of Resident 82's Minimum Data Set (MDS-), dated 1/6/2025, the MDS indicated Resident 82 had the ability to understand others. The MDS indicated Resident 82 had the ability to express ideas and wants. During a concurrent observation and interview on 5/6/2025 at 2:06 PM with Resident 82, Resident 82 pointed to his screen door and stated the hole has been there for four months. Resident 82 stated the hole had been there since he was admitted to the facility. During an interview on 5/8/2025 at 12:37 PM with Certified Nurse Assistant (CNA) 4, CNA 4 stated Resident 82 has a hole in his screen. CNA 4 stated he noticed the hole in the screen today but has not reported it to anyone. During a concurrent interview and record review on 5/9/2025 at 10:30 a.m. with, Maintenance Supervisor (MS), the Primex Rooms Preventative Maintenance Checklist , dated 3/14/2025, was reviewed. The Primex Rooms Preventative Maintenance Checklist indicated the sliding door was checked. The MS stated the rooms are checked monthly for repairs. The MS stated the screen door was replaced yesterday. The MS stated he could not provide any other documentation for Resident 82's room being checked for repairs. The MS stated Resident 82 will be at risk of injury and unwanted pest. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2012, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. `