STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055541	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Terrace Healthcare	1340 Highland Ave. Duarte, CA 91010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide privacy for one of one sampled resident (Resident 30) when staff did not close the privacy curtain while checking Resident 30's Gastrostomy tube (G-tube, feeding tube that is surgically placed through an opening into the stomach from the abdominal wall) site. This deficient practice violated Resident 30's right to bodily privacy and resulted in unnecessary exposure of Resident 30's abdominal area and lower extremities. This deficient practice had the potential to affect Resident 30's psychosocial (mental and emotional) well-being, self-esteem, and self-worth. Findings: During a review of Resident 30's admission Record (AR), the AR indicated Resident 30 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dysphagia (difficulty swallowing). During a review of Resident 30's Physician Order (PO) dated 3/20/2025, the PO indicated for staff to administer Nutren 2.0 (liquid formula used for G-tube feeding) at 60 cubic centimeters per hour (cc/hr.- unit of measurement) for 20 hours to provide 1,200 cc per 2,400 kilo calories (kcal, unit of energy) in 24 hours turn on at 2 p.m., turn off at 10 am or until total volume is infuse via pump (medical device used to deliver tube feeding). During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/24/2025, the MDS indicated Resident 30 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 630 was dependent (helper does all of the effort) on staff for oral hygiene, toileting, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 5/27/2025 at 8:40 a.m. with the Director of Staff Development (DSD), in Resident 30's room, Resident 30 was awake, lying in bed. The DSD pulled up Resident 30's gown and checked Resident 30's G-tube site. The DSD did not close Resident 30's privacy curtain to provide Resident 30 privacy, exposing Resident 30's abdominal area and lower extremities to Resident 30's roommate and hallway. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/2025 at 8:42 a.m. with the DSD, the DSD stated the DSD pulled up Resident 30's gown to check Resident 30's G-tube site and did not close the privacy curtain to provide Resident 30 privacy, exposing Resident 30's abdomen and lower extremities. The DSD stated privacy curtain needed to be closed during ADLs to provide privacy. During an interview on 5/28/2025 at 1:55 p.m. with the Director of Nursing (DON), the DON stated Resident 30s' privacy curtain needed to be closed during care and ADLs to provide dignity by not exposing Resident 30's body parts. During a review of the facility's policy and procedure (P&P) titled, Quality of Life-Dignity, revised 2/2020, the P&P indicated, staff promote, maintain and protect resident privacy, including privacy during assistance with personal care and during treatment procedures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when needed) was within reach and appropriate to the patient's physical ability for one of one sampled resident (Resident 29). This failure had the potential to result in a delay in meeting Resident 29's needs for assistance and could have led to a fall or accident. Findings: During a review of Resident 29's admission Record (AR), the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses that included muscle weakness and contractures of both hips, both knees and the left elbow. During a review of Resident 29's History & Physical (H&P), dated 10/17/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 4/12/2025, the MDS indicated Resident 29 had intact cognition (ability to understand), had upper extremity (shoulder, elbow, wrist, hand) impairment on one side, and required partial/moderate assistance (helper does less than half the effort. Helper lifts or holds, or supports trunk or limbs, but provides less than half the effort) to roll left and right (roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 29's Care Plan, dated 4/27/2025, the Care Plan indicated Resident 29 had limited physical mobility related to generalized weakness and contractures. During a review of Resident 29's Occupational Therapy Evaluation and Plan of Treatment (OTE), dated 4/30/2025, the OTE indicated Resident 29 demonstrated decreased strength, balance, activity tolerance, and safety and Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 5/27/2025 at 9:59 a.m. while in Resident 29's room, Resident 29 was lying on his left side and was unable to locate his call light. Certified Nurse Assistant 1 (CNA 1) stated it was behind the resident's right backside and handed it to the resident. The resident stated, he was unable to reach the call light. During an interview on 5/27/2025 at 10:03 a.m. with Licensed Vocational Nurse 1 (LVN 1) at Resident 29's bedside, LVN 1 stated the call light should be within the resident's reach to allow the resident to get help if needed. LVN 1 stated, if Resident 29 couldn't get help when needed he will scream, but stated he should not have to do that. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2025 at 10:02 a.m. with the Director of Nursing (DON), the DON stated Resident 29 had a limited range of motion and the call light should have been within reach to accommodate his call light use. The DON further stated, the call light should be within reach of the resident, on the bed or wherever they prefer within their reach. The DON stated, if the call light was on the ground they may reach for it and fall or won't get assistance when needed because they wouldn't have the call light to use. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated 2001, the P&P indicated, the purpose of the call light procedure is to respond to the resident's requests and needs and ensure the call light is accessible to the resident when in bed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** b. During a review of Resident 93's AR, the AR indicated Resident 93 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (irreversible kidney failure), hydronephrosis (a condition characterized by excess fluid in a kidney due to a backup of urine) and dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 93's MDS, dated [DATE], the MDS indicated Resident 93 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 93 required partial/moderate assistance (helper did less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 93 required substantial/maximal assistance (helper did more than half the effort) with toileting and shower. During a concurrent interview and record review on 5/27/2025 at 10:18 a.m. with the Social Services Director (SSD), Resident 93's medical record (chart) and electronic medical record (EMR) were reviewed. SSD stated there was no copy of an AD or AD acknowledgement form in Resident 93's chart or EMR. The SSD stated a copy of an AD and ADA form should be updated and, in the chart, and/or uploaded into the EMR of the resident with each admission or readmission and accessible for the staff to know the resident's wishes and preferences in case of an emergency and how to care for the resident while residing in the facility. During an interview on 5/28/2025 at 1:54 p.m. with the DON, the DON stated, all residents should have an updated copy of their AD and ADA form in the chart and/or uploaded in the EMR indicating residents and/or the resident's representative were provided with information on their rights to refuse or receive medical treatment and how to formulate an AD upon admission or readmission. The DON stated the AD and ADA forms needed to be filled out completely and signed with each admission and readmission to honor the resident's wishes, preferences and changes in the plan of care while in the facility. During a review of the facility's P&P titled Advance Directives dated 9/2022, the P&P indicated prior to, or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&P indicated the resident, or representative will be provided with written information concerning the resident's right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or chooses to do so. Based on interview and record review, the facility failed to ensure Advance Directives (AD, a legal document indicating resident preference on end-of-life treatment decisions) and AD Acknowledgement Forms were filled out completely and correctly and added to the resident's medical record for two of three sampled residents (Residents 3 and 93) in accordance to the facility's policy and procedure (P&P) titled Advance Directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficient practice had the potential to cause confusion among the healthcare workers in the event Residents 3 and 93 required immediate medical care and/treatment and had the potential for the residents to receive inadequate or medically unnecessary care and/or treatment or services regarding life-sustaining treatment. Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 3's AD Acknowledgement Form dated 4/29/2025, Resident 3's AD Acknowledgment Form was not filled out completely. During a review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/1/2025, the MDS indicated Resident 3 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 was dependent (helper does all of the effort) to staff for toileting hygiene and shower. The MDS indicated, Resident 3 required partial/moderate (helper does less than half the effort) from staff for oral hygiene and personal hygiene. During an interview with the Social Worker (SW), and concurrent record review of Resident 3's AD Acknowledgement Form on 5/27/2025 at 10:49 a.m., the SW stated, the AD Acknowledgement Form was not filled out completely. The SW stated, the AD Form needed to be filled out completely and accurately because it indicated the residents' medical wants and wishes. During an interview on 5/28/2025 at 1:53 p.m. with the facility's Director of Nursing (DON), the DON stated, the AD Acknowledgement Form needed to be discussed by the SW with the RP and/or resident and completely filled out upon admission. The DON stated the AD Acknowledgement Form needed to be filled out accurately and completely in cases of emergency, it was the residents' right for the facility staff to follow the residents' wants and wishes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized and comprehensive hospice plan of care for one of two sampled residents (Resident 95). This failure had the potential for Resident 95 to not receive the necessary care, treatment, and services. Findings: During a review of Resident 95's admission Record (AR), the AR indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included cirrhosis (a condition in which the liver is scarred and permanently damaged), hepatic encephalopathy (loss of brain function when a damaged liver doesn't remove toxins from the blood) and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 95's Order Summary Report (OSR), dated 5/22/2025, the OSR indicated Resident 95 was admitted to the facility on hospice. During a concurrent interview and record review on 5/28/2025 at 11:19 a.m. with the Social Services Director (SSD), Resident 95's hospice medical record (chart) and electronic medical record (EMR) were reviewed. The SSD stated Resident 95 did not have a hospice care plan developed and initiated by the hospice provider and the facility. The SSD stated all residents on hospice should have a comprehensive, individualized and coordinated care plan developed and initiated upon admission to determine and address Resident 95's care needs, goals and interventions. During an interview on 5/28/2025 at 1:53 p.m. with the Director of Nursing (DON), the DON stated all residents on hospice should have a hospice care plan developed by both the hospice provider and the facility to address in a coordinated manner the specific needs of the resident to promote physical and psychosocial well-being. During a review of the facility's undated Policy and Procedures (P&P) titled, Hospice Care, the P&P indicated, When a facility resident elects to have hospice care, the facility staff communicates with the hospice agency to establish and agree upon a coordinated plan of care that is based upon an assessment of the resident's needs and living situation in the facility. Develop a plan of care that reflects the participation of the hospice agency and the facility, and the resident and family to the extent possible.

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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 ensure the Low Air Loss (LAL) mattress (Alternating Pressure Mattress which provides alternating pressure and is designed to be used in the prevention, treatment and management of pressure injury which is a localized damage to the skin and underlying soft tissue usually over a bony prominence and maybe caused by intense or prolonged pressure over the site) was set up accurately according to manufacturer's instruction for one of two sampled residents (Resident 6). This deficient practice had the potential to result in the risk of reoccurring of pressure injury for Resident 6. Findings: During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pressure ulcer (lesion/wound caused by unrelieved pressure that results in damage of underlying tissue) of sacral (large, triangular bone at the base of the spine) region Stage 4 (ulcer that extends into the muscle and bone and causing extensive damage) and morbid (severe) obesity (condition in which the body mass index [BMI, scale that helps medical professionals determine if a person is within a healthy weight range] is over 40 or is 100 pounds over their ideal body weight which is a serious health condition that can interfere with basic physical functions such as breathing or walking) due to excess calories (a standard unit of measuring energy). During a review of Resident 6's untitled CP initiated on 2/25/2025, the CP indicated Resident 6 had impaired skin integrity related to a sacral coccyx (the fused sacrum and coccyx [the triangular arrangement of bone that makes up the very bottom portion of the spine below the sacrum]) Stage 4 pressure injury. The CP interventions included that Resident 6 would have a low air loss mattress for wound management and for staff to monitor for function and placement, and the low air loss mattress settings to be according to the residents' weight/personal preference. During a review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/7/2025, the MDS indicated Resident 6 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort) to staff for eating, oral hygiene, toileting hygiene, shower, lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 6's Monthly Weight and Vitals Summary, it indicated Resident 6 was 144 lbs. on 5/19/2025. During a review of Resident 6's Order Summary Report (OSR) dated 5/27/2025, the OSR indicated Resident 6 may have a low air loss mattress for wound management. The OSR indicated to monitor for function and placement, and the LAL mattress settings are to be according to residents' weight/personal preference. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 5/27/2025 at 8:29 a.m., with the Director of Staff and Development (DSD), Resident 6 was observed awake and lying on a LAL mattress. Resident 6's LAL mattress was set between 350 pounds (lbs., unit of measurement) to firm. The DSD stated the LAL mattress was on the wrong setting. The DSD stated, the weight setting should be set up by Resident 6's actual weight. During an observation and concurrent interview on 5/27/2025 at 8:32 a.m., with the Infection Prevention Nurse (IPN), the IPN stated, the setting should be in between 150 lbs. to 180 lbs. The IPN stated, the LAL mattress should be set up according to Resident 6's weight. During an interview on 5/27/2025 at 8:38 a.m. with Resident 6, Resident 6 stated The bed was not firm anymore as compared before. During an interview on 5/28/2025 at 1:57 p.m. with the facility's Director of Nursing (DON), the DON stated, the LAL mattress needed to be set up based on the residents' weight and preference comfort level or it would defeat the purpose which is to prevent deterioration of wounds and/or to prevent from developing pressure injury if not set up based on the residents' weight. During a review of the undated user manual titled, DynaRest Airfloat 100 Air Mattress with Pump, the user manual indicated to turn the pressure adjust knob (adjustable by patient's weight) to set a comfortable pressure level by using the weight scale as a guide.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services 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 dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents had a dialysis emergency kit (E-kit, contains the main items needed in an emergency) at the bedside for one of three sampled residents (Resident 93). This failure had the potential to result in Resident 93 to not receive or to receive delayed care and emergency treatment from complications caused by unexpected bleeding from the hemodialysis access site. Findings: During a review of Resident 93's admission Record (AR), the AR indicated Resident 93 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (irreversible kidney failure), hydronephrosis (a condition characterized by excess fluid in a kidney due to a backup of urine) and dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 93's Care Plan (CP), dated 12/23/2024, the CP indicated Resident 93 needed hemodialysis related to acute renal failure (ARF, a condition in which the kidneys suddenly can't filter waste from the blood). The CP goals indicated Resident 93 would have immediate intervention should any signs and symptoms of complications from dialysis occur. During a review of Resident 93's Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2025, the MDS indicated Resident 93 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 93 required partial/moderate assistance (helper did less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 93 required substantial/maximal assistance (helper did more than half of the effort) with toileting and shower. During a concurrent observation and interview while inside Resident 93's room on 5/27/2025 at 9:03 a.m. with Certified Nurse Assistant 2 (CNA 2), Resident 93 was in bed, on his back with an hemodialysis access site on Resident 93's left upper chest. CNA 2 stated Resident 93 did not have an E-kit at the bedside. CNA 2 stated Resident 93 should have an E-kit at the bedside for use in case of bleeding from the dialysis access site. During an interview on 5/28/2025 at 2:02 p.m. with the Director of Nursing (DON), the DON stated all dialysis residents needed to have an E-kit at the bedside with supplies readily available and accessible in an emergency like bleeding from the dialysis access site. During a review of the facility's Policy and Procedures titled, Hemodialysis Access Care, revised September 2010, the P&P indicated, Mild bleeding from site (post-dialysis) can be expected. Apply pressure to insertion site and contact dialysis center for instructions. If there is major bleeding from the site (post-dialysis), apply pressure to the insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer Dilaudid (a controlled pain medication) within ordered parameters for one of four sampled residents (Resident 193). This failure resulted in professional standards of practice not being followed and had the potential to ineffectively manage Resident 193's pain. Findings: During a review of Resident 193's admission Record (AR), the AR indicated Resident 193 was admitted to the facility on [DATE] with diagnoses that included multiple left-sided rib fractures and high blood pressure. During a review of Resident 193's History & Physical (H&P), dated 5/14/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 193's Minimum Data Set (MDS, a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 193 had intact cognition (ability to understand). During a review of Resident 193's Order Summary Report, the report indicated Resident 193 had an active order for Dilaudid oral tablet 2 milligram (mg) (Hydromorphone HCl) -give one (1) mg. by mouth every four hours, as needed for moderate pain (4-6) on the pain scale (a pain rating scale of zero being no pain, and 10 being the worst possible pain, severe pain is rated as 7-10 on a 1-10 scale) and was ordered on 5/12/2025. During a review of Resident 193's Care Plan, dated 5/27/2025, the care plan indicated Resident 193 was receiving Dilaudid for pain medication therapy and should be administered as ordered by the physician. During a medication administration observation on 5/29/2025 at 8:12 a.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 administered 1 mg of Dilaudid for moderate pain (4-6) to Resident 193 after assessing Resident 193's pain to be a seven out of 10 on the pain scale. LVN 2 stated, the Dilaudid was indicated for moderate pain at the level of four to six. LVN 2 stated, pain medication for severe pain was unavailable for Resident 193 and would re-assess Resident 193's pain then contact the physician for another order. During a concurrent observation and interview on 5/29/2025 at 10:18 a.m. with Resident 193 in Resident 193's room, Resident 193 was sitting calmly on his bed. Resident 193 stated he had several broken ribs for which he received the Dilaudid and a lidocaine patch (patch used to reduce pain). Resident 193 stated, if he needed more pain medication he would request it from the nurses. (continued on next page)

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	055541	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Terrace Healthcare	1340 Highland Ave. Duarte, CA 91010

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2025 at 10:04 a.m. with the Director of Nursing (DON), the DON stated the physician should have been notified by the charge or desk nurse to get the appropriate orders and address Resident 193's pain level. DON stated, the physician's ordered parameters were not followed, the pain medication given should have been for the treatment of severe pain. DON further stated, this could have led to ineffective pain management for Resident 193. DON further stated, not following the parameters of physician orders for other medications could lead to more severe consequences on the resident. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated, medications are administered in accordance with prescriber orders. During a review of the facility's policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, revised 4/2014, the P&P indicated, a medication error is defined as the preparation for administration of drugs or biological which is not in accordance with physician's orders .or accepted professional standards and principles of the professional(s) providing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure the medication refrigerator (MR) was maintained at a temperature between 36 degrees Fahrenheit (F, unit of measurement for temperature) to 46 degrees F for one of one sampled medication refrigerator. This failure had the potential to result in medications stored in the medication refrigerator to become unstable and ineffective. Findings: During a review of the Medication Refrigerator MR temperature recording log, dated 5/2025, the MR temperature recording log indicated, the MR had a temperature recorded at 48 degrees F on 5/23/2025 and 5/24/2025. During a concurrent observation and interview while inside the facility's medication room on 5/29/2025 at 11:22 a.m. with Licensed Vocational Nurse 3 (LVN 3), the MR's temperature was 34 degrees F. LVN 3 stated the MR's temperature should always be kept between 36 to 46 degrees F. LVN 3 stated not keeping the temperature of MR between 36 to 46 degrees F might reduce the medications efficacy and effectiveness. During an interview on 5/29/2025 at 12:50 p.m. with the Director of Nursing (DON), the DON stated keeping the MR out of the recommended temperature range might affect and alter the stability, effectiveness and efficacy of the medications stored. During a review of the facility's undated Policy and Procedure (P&P) titled, Temperature Control, the P&P indicated, Drugs requiring refrigeration shall be stored in a refrigerator between two degrees Celsius (C, unit of measurement for temperature based on water) or 36 degrees°F and 8 \degrees°C or 46 degrees°F. A Daily Medication Refrigerator Temperature log will be kept to assure that the temperature is maintained. Adjustments are made to the thermostat control as needed.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage in one of one facility's kitchen by failing to: a. Ensure leftover food from outside the facility was not stored in the kitchen refrigerator. b. Label food items and supplies in the dry storage area with a date open receipt, opened and used/best by date. c. Discard expired food items in the dry storage area. These failures had the potential to result in harmful bacteria growth and cross-contamination (transfer of harmful bacteria from one place to another) that would lead to foodborne illness (an illness caused by eating contaminated food). Findings: a. During a concurrent observation and interview on 5/27/2025 at 8:11 a.m. with the Lead [NAME] (LC) in the facility's kitchen refrigerator there were two (2) to-go boxes inside a white plastic bag with leftover beef, chicken, macaroni salad and rice in the refrigerator which were not labeled and dated. These were stored together with food for the residents in the facility. The LC stated all food items in the kitchen refrigerator should be labeled with the date received, opened and used by date to make sure the food served in the facility was at the highest quality. LC stated leftover food from outside the facility should not be stored in the kitchen refrigerator for infection control purposes. b. During a concurrent observation and interview on 5/27/2025 at 8:40 a.m., with the Dietary Supervisor while inside the facility's dry storage area, the following food items did not have a delivery date, opened date and used by date: b1. One (1) box of open Nestle Rich Chocolate powder b2. Five (5) boxes of unopened [NAME] Ready Care (Thickened Lemon Flavored Water) b3. One (1) bag of hotdog buns b4. Two (2) cans of Real Fresh Ready to Serve Chocolate Pudding c. During a concurrent observation and interview on 5/27/2025 at 8:54 a.m. with the DS inside the facility's dry storage area, a gallon of opened Teriyaki sauce with use by date of 5/2/2025 was in the rack. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DS stated all food items stored in the kitchen refrigerator, freezer, and dry storage area should be labeled with the delivery date, opened date and used by date to make sure food stored was within the recommended shelf-life. The DS stated all expired food items should be discarded to make sure food served to the residents was maintained at its best quality. The DS stated food from outside the facility should not be stored inside the kitchen refrigerator, freezer and dry storage area to prevent cross-contamination. During a review of the facility's undated Policy and Procedures (P&P) titled, Refrigerators and Freezers, the P&P indicated, All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. Supervisors will be responsible for ensuring food items in the pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes. During a review of the facility's undated P&P titled, Food Receiving and Storage, the P&P indicated, All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Partially eaten food is not kept in the refrigerator.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident area for two out of twenty-three resident rooms (rooms [ROOM NUMBERS]). This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During a review of the Client Accommodations Analysis (CAA), dated 5/27/2025, the CAA indicated rooms [ROOM NUMBERS] had a 156 square feet of floor area and two beds. During a review of the facility's letter to request for room waiver dated 5/27/2025, the letter indicated the facility was requesting a waiver be granted on the condition that the request did not adversely affect any residents or any resident's special needs. The waiver indicated all proposed rooms provided ample space for safe resident mobility and accessibility and would not impede the ability of any residents in the room to attain their highest practical well-being. During the Health Recertification Survey, from 5/27/2025 to 5/30/2025, rooms [ROOM NUMBERS] had adequate space, nursing care, comfort, and privacy was provided to the residents. There was adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (is a device that gives additional support to maintain balance or stability while walking,) and Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). The residents were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. The room size did not affect the care and services provided by the staff to the residents when staff were observed providing care to the residents. There were no residents who expressed any concerns about the room sizes. During an interview on 5/30/2025 at 9:19 a.m. with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated room [ROOM NUMBER] had adequate space to provide care to the resident. CNA 3 stated, she was able to use the Hoyer lift and other equipment while inside the room without any issues and the resident was able to use their walkers comfortably. During an interview on 5/30/2025 at 9:24 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated room [ROOM NUMBER] had enough space to comfortably provide care and treatment to the resident and could transfer the resident with the Hoyer Lift while inside the room without issue. During an interview with the Facility Administrator (ADM) on 5/30/2025 at 2:50 p.m., the ADM stated the facility was requesting a room waiver (a document recording the waiving of a right or claim) this year for rooms [ROOM NUMBERS]. The ADM stated nothing was changed with the bed occupancy number in either of the two rooms.