STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055575	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Haven Subacute and Healthcare Center	12072 Trask Ave. Garden Grove, CA 92843

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 19 final sampled residents (Resident 30) was safe to self-administer a medication. * There was no assessment or care plan to address Resident 30's self-administration of medications when the resident had two bottles of Alphagan eye drops (medication used to lower high eye pressure) at the bedside and had been self-administered this medication. This failure had the potential to negatively impact the residents' well-being and administer the medications inaccurately. Findings: Review of the facility's P&P titled Self-Administration of Medications (undated) showed each resident will be informed of his/her right to self-administer medication. The residents will be informed that they have a right to self-administer drugs upon admission. Medical record review for Resident 30 was initiated on 4/29/25. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 30's H&P examination dated 2/15/25, showed Resident 30 had the capacity to understand and make decisions. On 4/30/25 at 1443 hours, an observation and concurrent interview was conducted with Resident 30. Two bottles of Alphagan eyedrop were observed in the bedside drawer. Resident 30 stated he had been administering the eyedrop medication since he was admitted to the facility. On 4/30/25 at 1447 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the two bottles of Alphagan at the bedside and stated medications must have an order. LVN 1 further stated it was not safe for the resident to keep the medications at the bedside. Review of Resident 30's medical record failed to show documented evidence of the following for Resident 30 to safely self-administer medications: - a physician's order for the Alphagan medication; - self-administration assessment of the medication; and (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a care plan addressing Resident 30's self- administration of the medication. On 4/30/25 at 1604 hours, an interview and concurrent medical record review for Resident 30 was conducted with the ADON. The ADON was informed of the medication at Resident 30's bedside and stated any medication must have the order, self-administration assessment, and care plan to self-administer a medication. The ADON stated it was not safe to keep the medications at bedside. The ADON verified there were no physician's order, self-administration assessment, and care plan for Resident 30's use of the Alphagan medication. On 4/30/25 at 1608 hours, an interview and concurrent medical record review for Resident 30 was conducted with the DON. The DON was informed and verified the above findings.

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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 0578 Level of Harm - Potential for minimal 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** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to obtain a copy of the advance healthcare directive for one of six final sampled residents (Resident 32) reviewed for advance directives. This failure had the potential for the resident's decisions regarding their healthcare and treatment options to not be honored. Findings: Review of the facility's P&P titled Advance Directives and Associated Documentation revised 12/2023 showed the following: - It is the policy of the facility that a resident's choice about advance directives will be recognized and respected. Further, it is the policy of the facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. The facility recognizes and respects the resident's right to choose their treatment and make decisions about care to be received at the end of their life; - Obtain copy of the advance directive and conservatorship/guardianship documents and in the resident health record; and - Once the advance directive or information regarding resident preferences regarding treatment options is received by the facility, it will be confirmed in the resident medical record and communicated to the members of the care plan team. Medical record review for Resident 32 was initiated on 4/29/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's POLST dated 4/2/25, under Section D Information and Signatures showed Resident 32's Advance Directive dated 4/11/25, was available and reviewed. Review of Resident 32's MDS assessment dated [DATE], showed Resident 32 had a severe cognitive impairment. Review of Resident 32's medical record showed a copy of Resident 32's California General Durable Power of Attorney dated 10/1/22, for financial matters. Further review of Resident 32's medical record did not have documented evidence to show a copy of the resident's advance healthcare directive was obtained. (continued on next page)

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	On 5/5/25 at 1044 hours, an interview and concurrent medical record review for Resident 32 was conducted with RN 3. RN 3 stated the social worker and physician reviewed the POLST form, and the social worker followed up for the advance directives. On 5/5/25 at 1049 hours, an interview and concurrent medical record review for Resident 32 was conducted with the SSD and Social Services Resource staff. The SSD stated the social services department staff was responsible for initiating and completing the POLST. The SSD further stated the social services department staff was also responsible for following up with the resident's advance healthcare directives. The SSD verified Resident 32's POLST showed Resident 32's advance directive was available and reviewed. The SSD and the Social Service Resource staff verified Resident 32's copy of advance healthcare directive was not obtained and not in Resident 32's medical record. The SSD and Social Service Resource further verified Resident 32's DPOA for finance was in the resident's medical record but not her advance healthcare directive.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of 19 final sampled residents (Resident 78) was free from unnecessary psychotropic medications. * The facility failed to ensure Resident 78's prescription for lorazepam (antianxiety medication) had documentation of the physician's clinical rationale to show when the PRN order was extended beyond 14 days. This failure had the potential to negatively impact the Resident 78's well-being from the continued use of the lorazepam medication. Findings: Review of the facility's P&P titled Psychotropic Medications revised 12/2023 showed the following: - Based on comprehensive assessment, the facility will ensure PRN orders for psychotropic drugs are limited to 14 days. Except for PRN orders for antipsychotic medications, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN psychotropic medication order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order; and Medical record review for Resident 78 was initiated on 4/29/25. Resident 78 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 78's H&P examination dated 3/12/25, showed Resident 78 had no capacity to understand and make decisions. Review of Resident 78's medical record showed the following physician's orders for the lorazepam medication: - dated 3/10/25, to administer lorazepam 1 mg via GT every 12 hours as needed for anxiety manifested by hyperventilation; - dated 3/14/25, to administer lorazepam 1 mg via GT every 12 hours as needed for anxiety manifested by hyperventilation for 14 days, until 3/24/25; - dated 4/1/25, to administer lorazepam 1 mg via GT every 12 hours as needed for anxiety manifested by hyperventilation. This order was completed on 4/8/25; - dated 4/9/25, to administer lorazepam 1 mg via GT every 12 hours as needed for anxiety manifested by hyperventilation for 14 days. This order was completed on 4/23/25; and - dated 4/25/25, to administer lorazepam 1 mg via GT every 12 hours as needed for anxiety manifested by hyperventilation for 14 days. This order was to be completed on 5/9/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 78's MAR for April to May 2025 showed Resident 78 was administered the lorazepam medication on 4/2, 4/3, 4/9, 4/10, 4/11, 4/12, 4/16, 4/17, 4/20, 4/21, and 4/22/25. Further review of Resident 78's medical record did not show documentation of the clinical rationale from the prescribing physician when the use of lorazepam medication was extended and ordered on 4/1 to 4/8/25, on 4/9 to 4/23/25, and on 4/25 to 5/9/25. On 5/2/25 at 0943 hours, an interview and medical record review for Resident 78 was conducted with RN 2. RN 2 verified Resident 78 had the physician's orders for the lorazepam medication, and the initial order was from 3/10 to 3/24/25. RN 2 verified Resident 78 also had the physician's orders for the lorazepam medication on 4/1 to 4/8/25, then 4/9 to 4/23/25, and another current order on 4/25 to 5/9/25. RN 2 was not able to show a documented evidence of the clinical rationale from the physician when the PRN order for the lorazepam medication was renewed after the initial order on 3/10/25.

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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** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for two of 19 final sampled residents (Residents 14 and 78) and one of three residents reviewed for closed records (Resident 8). * The facility failed to develop a care plan to address Resident 78's use of padded side rails. In addition, the facility failed to develop a care plan to address Resident 78's use of IV device. * The facility failed to develop a care plan to address Resident 14's use of the sequential compression device. * The facility failed to develop a care plan for Resident 8's DM. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents. Findings: 1. On 4/29/25 at 1056 and 1454 hours, 4/30/25 at 1118 and 1609 hours, 5/1/25 at 0845, 1333, and 1601 hours, and 5/2/25 at 0837 and 0858 hours, Resident 78 was observed in bed with the bilateral padded grab bars elevated. Resident 78 was also observed with an IV site on the right forearm. Medical record review for Resident 78 was initiated on 4/29/25. Resident 78 was readmitted to the facility on [DATE]. Review of Resident 78's Order Summary Report showed the following physician's orders: - dated 4/11/25, to continue use of bilateral assistive bars as enabler for bed mobility and repositioning per resident and resident representative request; - dated 4/26/25, to administer Zosyn (antibiotic) IV solution 3-0.375 gm/50 ml every eight hours for pneumonia for ten days; and - dated 4/26/25, to monitor IV site for continuous and intermittent therapy, site check on the peripheral line to right forearm. Review of Resident 78's plan of care did not show a care plan was developed to address Resident 78's use of the padded side rails. In addition, review of the resident's plan of care did not show a care plan was developed to address Resident 78's IV device. On 5/1/25 at 1336 hours, an observation for Resident 78 and concurrent medical record review was conducted with LVN 3. Resident 78 was observed lying in bed with the bilateral padded side rails and had an IV site on the right forearm. LVN 3 verified Resident 78 had an IV site on the right forearm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/25 at 0943 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 was not able to show a care plan was developed to address Resident 78's use of the IV and padded side rails. On 5/2/25 at 1007 hours, an observation for Resident 78 and concurrent medical record review was conducted with the Subacute Clinical Care Coordinator. Resident 78 was observed lying in bed with bilateral padded side rails and had an IV site on the right forearm. The Subacute Clinical Care Coordinator verified Resident 78 had padded side rails. The Subacute Clinical Care Coordinator stated the padded side rails were requested by the resident and his representative, but there was no documentation of the said request for the padded side rails in Resident 78's medical records. 49644 2. Medical record review for Resident 14 was initiated on 4/29/25. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated 4/9/25, showed the resident had no capacity to understand and make decisions. Review of Resident 14's Order Summary Report dated 5/1/25, showed a physician's order dated 4/19/25, to apply sequential compression device to the bilateral lower extremities every shift for DVT prophylaxis, on at 2000 hours and off at 0800 hours. Review of Resident 14's plan of care failed to show a care plan to address the use of the sequential compression device. On 5/2/25 at 0956 hours, an interview and concurrent medical record review for Resident 14 was conducted with the ADON. The ADON verified there was no care plan for Resident 14's use of sequential compression device for the bilateral lower extremities. The ADON stated the licensed nurse who noted the order should have entered the order in Resident 14's care plan. On 5/2/25 at 1018 hours, an interview and concurrent medical record review for Resident 14 was conducted with RN 2. RN 2 verified there was no care plan for Resident 14's use of the sequential compression device for the bilateral lower extremities. RN 2 stated Resident 14 needed to be assessed, evaluated, and have a care plan for the sequential compression device. On 5/2/25 at 1456 hours, the DON and Subacute Clinical Coordinator were informed and acknowledged the above findings. 48332 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's P&P titled Policy/Procedure- Nursing Administration- Comprehensive Person-centered Care Planning, revised 8/2019 showed it is the policy of this facility that the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. Review of the facility's document titled Documentation Content of the Record Set (undated) showed the care plan is the foundation that provides direction to the interdisciplinary team and staff on providing care and treatment to the resident. The care plan should be the central focus for ongoing documentation of the resident's care, condition, and needs. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be provided to attain or maintain the resident's highest practicable physical, mental, and psychological well-being; any services that would otherwise be required but are not provided due to the residents' exercise of rights including the right to refuse treatment. The care plan must reflect intermediate steps for each outcome objectives if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may need to prioritize their care plan interventions. Closed medical record review for Resident 8 was conducted on 5/2/25. Resident 8 was admitted on [DATE], was readmitted on [DATE], and discharged on [DATE]. Resident 8's diagnoses included Type 2 DM, diabetic chronic kidney disease, and other diabetic ophthalmic (eye) complications. Review of Resident 8's Order Summary Report dated 5/2/25, showed the following orders dated 4/8/25: - Humalog KwikPen subcutaneous solution pen-injector 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if BS level = 70 - 150 mg/dl = 0; 151 - 200 mg/dl = 2 units; 201 - 250 mg/dl = 4 units; 251 - 300 mg/dl = 6 units; 301 - 350 mg/dl = 8 units; 351 - 400 mg/dl = 10 units; and Call MD if BS level < 70 mg/dl or > 400 mg/dl, subcutaneously - Empagliflozin (antidiabetic) oral tablet 25 mg (Empagliflozin) one tablet orally in the morning for DM - Glipizide (antidiabetic) oral tablet 10 mg one tablet orally two times a day for DM with food. Review of Resident 8's MAR for May 2025 showed the following: - Humalog Kwikpen subcutaneous solution pen-injector 100 unit/ml was administered per the sliding scale insulin parameter at 0630, 1130, 1630, and 2100 hours. - Empagliflozin oral tablet 25 mg was administered at 0900 hours. - Glipizide oral tablet 10 mg was administered at 0900 and 1700 hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's plan of care failed to show a care plan was developed for the resident's DM and oral antidiabetic medications. On 5/5/25 at 0837 hours, an interview and concurrent medical record review of Resident 8's care plan was conducted with the ADON and MDS Assistant. The ADON and MDS Assistant verified there was no comprehensive care plan for the resident's DM.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, and medical record review, the facility failed to provide the individualized and ongoing activity program to meet the needs and interests for one of two final sampled residents (Resident 78) reviewed for activities. * The facility failed to provide the activities for Resident 78 which met the resident's identified interests such as watching TV. This failure had the potential for Resident 78 to negatively impact the resident's well-being. Findings: On 4/29/25 at 1056 hours, during the initial tour of the facility, Resident 78 was observed awake in bed. The TV was turned off, and there was no other sensory stimulation provided for Resident 78. Medical record review for Resident 78 was initiated on 4/29/25. Resident 78 was readmitted to the facility on [DATE]. Review of Resident 78's Activity Assessment - V2 dated 3/13/25, showed Resident 78's current activity interests included watching TV/movies, keeping up with the news, and listening to music. Review of Resident 78's Care Plan Report showed a care plan problem dated 4/26/25, to address Resident 78's respiratory infection. The interventions/tasks included to monitor for evidence of depression or restlessness related to isolation status, encourage to communicate feelings and/ or activities 1:1 (one staff member to one resident) visits daily and provide with independent activities of choice as able. On 5/1/25 at 1333 hours, Resident 78 was observed awake in bed. The TV was turned off. The TV remote control and the call light were observed placed on top of the resident's abdominal area. When asked what he wanted, Resident 78 attempted to touch and press the TV remote control but was not able to. When asked if he wanted to watch the TV, Resident 78 answered yes. On 5/1/25 at 1336 hours, an observation for Resident 78 and concurrent interview was conducted with LVN 3. Resident 78 was observed awake in bed. LVN 3 asked Resident 3 if he wanted to watch TV and needed help to turned the TV on, Resident 78 answered yes. LVN 3 was observed turning the TV on for Resident 78. On 5/2/25 at 0837 hours, Resident 78 was observed awake in bed. The TV was on; however, there was no sound coming from the TV. The TV remote control was observed on the bedside table and out of Resident 78's reach. When asked if he wanted to have a sound from the TV, Resident 78 nodded. On 5/2/25 at 0843 hours, an interview and concurrent medical record review for Resident 78 was conducted with the Activities Director. The Activity Director stated Resident 78 liked to watch TV and listen to the radio. The Activities Director stated the activities staff visited the resident three to four times per week to provide activities such as bringing the radio to the resident's room so the resident could listen to the music, and the nurses could turn the TV on for the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/25 at 0858 hours, an observation for Resident 78 and concurrent interview was conducted with the Activities Director. Resident 78 was observed awake in bed. The TV was on; however, there was no sound coming from the TV. The TV remote control was observed on the bedside table and out of Resident 78's reach. The Activities Director verified the above findings. The Activities Director asked Resident 78 if he wanted the TV sound on, Resident 78 put his thumbs up. The Activities Director was observed turning the TV sound on for Resident 78. The Activities Director stated the nurses might have turned the TV on but there was no sound from the TV.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, and medical record review, the facility failed to the reported injury was addressed and reported to the resident's responsible party and the physician for one of 19 final sampled residents (Resident 6). This failure posed the risk of Resident 6's injury to worsen. Findings: Medical record review for Resident 6 was initiated on 5/1/25. Resident 6 was readmitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 3/24/25 showed Resident 6's diagnoses included sepsis, Parkinson's Disease, schizophrenia, and dementia. Resident 6 had no capacity to understand and make decisions. On 5/1/25 at 1046 hours, a concurrent observation and interview for Resident 6 was conducted with CNA 1. CNA 1 verbalized Resident 6 was alert but confused and was able to propel himself in his wheelchair. When asked about the skin conditions for Resident 6, CNA 1 verbalized Resident 6 did not have any skin conditions. However, Resident 6 was observed with a red colored circular wound between the first and second fingers of the left hand. The wound measured approximately one-half inch diameter. When asked about this wound, CNA 1 stated sometimes Resident 6 banged his hands against things. On 5/1/25 at 1446 hours, an interview was conducted with LVN 7. When asked about any skin treatments for Resident 6, LVN 7 stated she applied A&D (ointment) daily to Resident 6's skin. Review of Resident 6's plan of care showed a care plan problem addressing Resident 6's skin integrity. The interventions included reporting skin conditions to Resident 6's physician and responsible party. On 5/2/25 at 1400 hours, a follow-up concurrent observation and interview for Resident 6 was conducted with CNA 1. Resident 6 was observed with the same red colored circular wound between the first and second fingers of the left hand. Resident 6 was observed to have hand tremors. When asked about Resident 6's wound, CNA 1 stated she did report the wound to LVN 7 yesterday and was told to leave the wound open to air. On 5/2/25 at 1439 hours, a concurrent interview and medical record review was conducted with LVN 8. When asked about Resident 6's wound, LVN 8 verbalized there was no documentation related to Resident 6's hand wound or any physician's orders to treat the wound. LVN 8 further verified there was no report made to Resident 6's responsible party or physician.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, and medical record review, the facility failed to ensure the necessary treatment and services were provided to maintain or improve their ROM functions and prevent further declining of the ROM functions for two of two final sampled residents (Residents 38 and 44) reviewed for ROM functions. * Residents 38 and 44 did not receive the restorative nursing treatment daily as ordered by the physician. This failure posed the risk for the residents to develop complications from immobility and not achieve their highest practicable level of independence. Findings: 1. Medical record review for Resident 38 was initiated on 4/29/25. Resident 38 was readmitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 38's H&P examination dated 12/4/24, showed Resident 38 had functional quadraplegia (paralysis). Resident 38 had the capacity to understand and make decisions. Review of Resident 38's care plan dated 4/30/25, showed Resident 38 was at high risk for decline in functional mobility and further decline in ROM functions due to decreased overall strength with the interventions, such as to provide AAROM exercises to the LUE and RUE every day five times per week as tolerated and PROM exercises to LUE and RUE every day five times per week as tolerated. Review of Resident 38's Order Summary Report for April 2025 showed an order dated 4/30/25, to provide AAROM exercises to LUE and RUE every day five times per week as tolerated; and the RNA order for PROM exercises to the LUE and RUE every day five times per week as tolerated. Review of Resident 38's Restorative Nursing for April 2025 showed the following: - For RNA AAROM exercises to the LUE and RUE every day shift five times per week, the boxes were left blank for 4/18, 4/19, 4/24, and 4/25/25. - For RNA PROM exercise to LLE every day shift five times per week, the boxes were left blank for 4/18, 4/19, 4/24, and 4/25/25. - For RNA PROM exercise to RLE every day shift five times per week, the box was left blank for 4/19/25. Review of Resident 38's RNA Therapy Weekly summary dated 4/15/25, showed the resident's response as cooperative to PROM exercises to the lower extremity and AAROM exercises to the upper extremity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 1430 hours, an interview and concurrent record review was conducted with RNA 1. When asked about the blank spaces on the Restorative Nursing documentation, RNA 1 stated she might have provided exercises that day but did not have the time to document. RNA 1 could not recall which specific days she had worked. RNA 1 stated RNA 2 was assigned to Resident 38 on some days. When asked if Resident 38 had refused RNA exercises, RNA 1 stated the resident did not refuse. RNA 1 acknowledged she should have signed the treatment record once the exercises were completed. RNA 1 stated they were in the process of transitioning to a new computer system, which led to a change in documentation from electronic records to paper records, causing her to forget to document. RNA 1 stated the RNAs were required to document in the RNA Therapy Weekly Summary each week. RNA 1 acknowledged the weekly documentation were missing for the periods 4/1/25 to 4/7/25, and 4/16/25 to 4/23/25, and verified the findings. On 5/5/25 at 0830 hours, an observation and concurrent interview was conducted with Resident 38. Resident 38 was observed sitting in bed. Resident 38 stated he had been receiving RNA exercises three times a week for the past two weeks. Resident 38 stated he did not ask the staff if he missed an exercise session, as he waited for the staff to provide the exercises. Resident 38 expressed a preference for receiving exercises five times per week. Resident 38 stated the RNA provided ROM exercises for both upper and lower extremities. When asked if he had refused these exercises, Resident 38 stated he had not. When asked if the staff had informed him when they were unable to provide RNA exercises on a given day, Resident 38 stated they had not. On 5/5/25 at 1420 hours, an interview and concurrent medical record review was conducted with RNA 2. RNA 2 was asked if he had provided RNA exercises on 4/18, 4/19, 4/24, and 4/25/25. RNA 2 stated he could not recall which day but he had always provided RNA exercises to Resident 38's upper and lower extremities. RNA 2 stated he forgot to sign the documentation because he could not locate the paperwork due to the transition in the documentation process. When asked if Resident 38 had refused RNA exercises, RNA 2 stated he had not. RNA 2 verified the above findings. 39453 2. On 4/29/25 at 1153 hours, and 4/30/25 at 1111 hours, Resident 44 was observed in bed, and both hands were observed contracted. There were no splints observed to both hands. Medical record review for Resident 44 was initiated on 4/29/25. Resident 44 was readmitted to the facility on [DATE]. Review of Resident 44's MDS assessment dated [DATE], showed Resident 44 had severe cognitive impairment and impairment to the upper and lower extremities. The resident was dependent to the facility staff member assistance for self-care and mobility. Review of Resident 44's Order Summary Report showed the following physician's orders: - dated 3/31/25, to continue RNA to apply the left resting hand splint for four hours per day as tolerated for five times a week; - dated 3/31/25, to continue RNA to apply the left elbow splint for four hours per day as tolerated for five times a week; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 3/31/25, to continue RNA to apply the left knee splint for four hours per day as tolerated for five times a week; - dated 4/11/25, to continue RNA for PROM exercises to the bilateral lower extremities; and - dated 4/11/25, to continue RNA for PROM exercises to the bilateral upper extremities. On 4/30/25 at 1150 hours, an observation for Resident 44 and concurrent interview was conducted with CNA 4. Resident 44 was observed in bed with no splints on both hands. CNA 4 verified there were no hand, elbow, and knee splints applied to Resident 44. CNA 4 stated the RNAs applied the splint to the residents. When asked to show where the splints were stored when not in use, CNA 4 found the hand splint in the bottom drawer of the resident's nightstand and the knee splint inside the resident's closet. On 5/1/25 at 1600 hours, Resident 44 was observed in bed with no splints applied to both hands. On 5/5/25 at 1330 hours, an observation for Resident 44 and concurrent interview and medical record review was conducted with RNA 1. Resident 44 was observed in bed with no splints applied to the left hand, elbow and knee. RNA 1 verified the above findings. RNA 1 was observed taking out the splint from the bottom drawer of the resident's nightstand and applied to Resident 44. RNA 1 stated the restorative nursing department was responsible for applying and removing the splints and performing PROM exercises to Resident 44. RNA 1 stated they documented the application of the splints and provision of the PROM exercises in the Restorative Nursing form last month; and they started documenting electronically this month. Review of Resident 44's Restorative Nursing form for April 2025 showed the RNAs' initials on the form to show the PROM exercises to the LLE, PROM exercises to the RLE, PROM exercises to the RUE, and the left knee splint, left elbow splint, and left resting hand splint were provided from Sunday to Thursday. However, there were missing staff' initials to show the PROM exercises to the LUE were provided on 4/10, 4/17, and 4/24/25. Review of Resident 44's Documentation Survey Report v2 for May 2025 showed 7.5 minutes were spent providing PROM exercises to the bilateral upper and lower extremities to Resident 44 on 5/1 and 5/4/25. Furthermore, the report showed five minutes were spent providing the splints on the left hand, left elbow, and left knee. Further review of Resident 44's medical record did not show documentation of how many hours Resident 44 had the splints on the left hand, left elbow, and left knee to know how many hours the resident could tolerate the splints. RNA 1 verified the above findings. RNA 1 verified there were missing initials on 4/10, 4/17, and 4/24/25. RNA 1 stated she did not work those days, and the other RNA might have forgotten to write down his initials. RNA 1 further stated they only documented the number of minutes spent on the application of the splints, and not the number of hours Resident 44 had the splints on. RNA 1 failed to show documented evidence how many hours Resident 44 had splints on left hand, left elbow, and left knee. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/5/25 at 1412 hours, an interview for Resident 44 was conducted with the Director of Rehabilitation and Assistant Director of Rehabilitation. The Director of Rehabilitation verified the RNAs were only documenting the number of minutes spent on the application of the splints, and not the number of hours the resident had the splints on to know if the resident could tolerate the splints and for how long.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on interview, medical record review, and facility P&P review, the facility failed to monitor the onset of weight loss for one of three final sampled residents (Resident 25) reviewed for nutrition. * The facility failed to ensure the RD's recommendations were followed up with the physician and addressed in the IDT Nutrition when Resident 25 had a significant weight loss of 11 lbs/11.1% in three months. This failure posed the risk of nutritional interventions not being implemented in a timely manner and potentially could cause the residents to have further weight loss. Finding: Review of the facility's P&P titled Weight Change Protocol dated 2023 showed early identification of a weight problem and possible cause(s) can minimize complications. Assessment of residents experiencing weight changes should be completed in a timely manner. The following Criteria define significant weight or insidious weight changes: - slow and progressive weight change trending away from weight goal. This can refer to weekly or monthly weights. - 3 lbs weight loss or gain in one week or as the facility policy states. - 5 lbs weight loss or gain in one month. - 5.0% weight loss or gain in one month. - 7.5% weight loss or gain in 3 months. - 10% weight loss or gain in 6 months. The facility RD will assess nutritionally diagnosis, suggest interventions, monitor, and evaluate the success of the interventions. Medical Record Review for Resident 25 was initiated on 4/29/25. Resident 25 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 25's Weight Summary showed the following weights: - dated 1/7/25, a weight of 99 lbs - dated 2/4/25, a weight of 92 lbs (weight loss of 7 lbs from 1/7/25) - dated 3/4/25, a weight of 87 lbs (weight loss of 5 lbs/7.5% from 2/4/25) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 4/1/25, a weight of 88 lbs (weight loss of 11 lbs /11.1% from 1/7/25) On 5/1/25 at 1136 hours, a concurrent interview and medical record review for Resident 25 was conducted with the ADON. Review of the Resident 25's IDT Nutrition dated 4/7/25, showed a recommendation to provide 2 Cal HN (a high-calorie, protein-dense nutritional formula) 60 ml three times a day, Health shake 4 ounces with lunch and dinner, and pudding at 1400 hours. The ADON failed to show the RD recommendation for the 2 Cal HN was communicated with the physician. The ADON verified Resident 25 was not monitored for the weight loss. On 5/1/25 at 1350 hours, a concurrent interview and medical record review for Resident 25 with the ADON. The ADON stated currently, Resident 25 had a weight loss of 3 lbs from the last recorded weight on 4/1/25. On 5/1/25 at 1401 hours, a concurrent interview and medical record review was conducted with the Food & Nutrition Services Director. The Food & Nutrition Services Director stated Resident 25's weight status should be monitored weekly.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 19 final sampled residents reviewed for enteral services received the appropriate treatment and services. Additionally, the enteral feedings were not properly stored or monitored. * The expired enteral feeding bottles were stored in the subacute storage unit. * The facility failed to ensure Residents 14 and 32's HOB were elevated at a 30 degree angle or above when the residents were receiving the enteral feeding via the GT. These failures posed the risk for complications related to the use of the enteral feeding for the residents. Findings: 1. On [DATE] at 1014 hours, a concurrent observation of the subacute storage unit and interview was conducted with Central Supply 1. Central Supply 1 verified four bottles of the enteral feeding formula bottles with a best before date of [DATE], and one bottle of enteral feeding with a best before date of [DATE]. Central Supply 1 verified the enteral feeding bottles were expired. 49644 2. Review of the facility's P&P titled Enteral Formulas, Administration of Closed System revised ,d+[DATE] showed the policy provides a means to safely administer a complete nutritional feeding to the resident using a premixed formula in a closed container system protecting formula from exposure to harmful contaminants. The Procedures section showed to elevate the HOB at least 30 degrees. Medical record review for Resident 14 was initiated on [DATE]. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated [DATE], showed the resident had no capacity to understand and make decisions. Review of Resident 14's Order Summary Report dated [DATE], showed the following physician's orders: - dated [DATE], to elevate HOB 30 to 45 degrees at all times during feeding every shift; - dated [DATE], to administer water set pump at 25 ml/hr for 20 hours to provide 500 ml via GT, and to start infusion at 12 noon and continue for 20 hours or until total volume is complete; and - dated [DATE], to administer Vital 1.5 (enteral feeding formula) set pump at 50 ml/hr for 20 hours to provide 1000 ml/1500 calories via GT, and to start infusion at 12 noon and continue for 20 hours or until total volume is complete. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 0735 hours, Resident 14 was observed lying in bed and receiving the enteral tube feeding with the HOB elevated less than 30 degrees . On [DATE] at 0747 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified Resident 14's HOB was elevated less than 30 degrees while the resident was receiving the enteral tube feeding. RN 1 stated Resident 14's HOB should have been elevated at 30 degrees to prevent aspiration (inhaling food, liquid or other material into the lungs). On [DATE] at 1417 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse practice was to elevate the HOB 30 to 45 degrees during feeding. The DON further stated if the resident could not tolerate the 30 degrees, the licensed nurse had to adjust the HOB a little bit. The DON stated the licensed nurse just approximate the HOB because the facility did not have the device to measure the exact angle of the HOB. 39453 3. According to Taylor's Fundamentals of Nursing seventh edition, Nursing Considerations with Tube Feeding, to make sure the resident is as upright as possible during feeding. If the resident is in bed during feedings, elevate the head of the bed at least 30 degrees during feeding and for one hour afterward to prevent reflux and aspiration. Medical record review for Resident 32 was initiated on [DATE]. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's H&P examination dated [DATE], showed the resident had no capacity to make medical decisions. Review of Resident 32's Order Summary Report showed the following physician's orders: - dated [DATE], to elevate the head of the bed at 30 to 45 degrees at all times during feeding; - dated [DATE], to administer Nepro (an enteral feeding formula) at 40 ml per hour for 20 hours to provide 800 ml/1440 kcal, 65 gm protein, and 582 ml free water via GT; and to start infusion at 1200 hours, and continue until 0800 hours, or until total volume is complete; and - dated [DATE], to flush the feeding tube with 250 ml water (for a total of 1000 ml per day) every six hours for hydration. On [DATE] at 1114 and 1120 hours, Resident 32 was observed lying in bed with the head of the bed elevated less than 30 degrees while receiving Nepro via a GT feeding pump at 40 ml per hour. On [DATE] at 1125 hours, an observation for Resident 32, concurrent interview, and medical record review was conducted with RN 2. Resident 32 was observed lying in bed with the head of the bed elevated less than 30 degrees while receiving Nepro via GT feeding pump at 40 ml per hour. RN 2 verified Resident 32's head of the bed was elevated less than 30 degrees while the resident was receiving the enteral tube feeding. RN 2 stated Resident 32's head of the bed should be elevated between 30 to 45 degrees.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of sampled residents (final sampled resident, Resident 32 and nonsample resident, Resident 63) reviewed for respiratory care received the appropriate treatment. * The facility did not ensure the nebulizer mask, tubing, and bag were changed weekly or properly labeled for Resident 63. * The facility failed to ensure Resident 32 was provided with the correct type of tracheostomy set for emergency use. Resident 32 was provided with an uncuffed tracheostomy set instead of a cuffed tracheostomy set. In addition, the facility failed to ensure the suction device was changed weekly as per the physician's order. These failures had the potential to negatively impact the respiratory health and overall well-being of the residents in the facility. Findings: 1. Medical record review for Resident 63 was initiated on 4/29/25. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 63's Order Summary Report for March 2025 showed an order dated 3/13/24, for the nebulizer to be changed every Sunday during the day shift and as needed. On 4/29/25 at 1120 hours, during the initial tour observation, Resident 63 was observed sitting upright in bed and receiving oxygen delivered via a T-mask attached to an oxygen concentrator set at five LPM. The nebulizer mask, tubing, and bag at the bedside were dated 4/20/25. On 4/29/25 at 1130 hours, a concurrent observation and interview was conducted with RN 6. RN 6 verified the nebulizer tubing, mask, and bag were dated 4/20/25. RN 6 stated the nebulizer tubing should be changed weekly on Sundays and should have been properly dated and labeled. On 4/29/25 at 1400 hours, a concurrent observation and interview was conducted with RCP 2. The nebulizer mask, tubing, and bag at the bedside were dated 4/20/25. RCP 2 stated the nebulizer tubing, mask, and bag should have been changed on Sunday 4/27/25. RCP 2 verified the findings. 39453 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. According to Taylor's Fundamentals of Nursing 2011 Seventh Edition, preparation for emergency situations is an important part of nursing care for residents with tracheostomy. The tracheostomy is the resident's only airway, and measures to maintain its patency need to be readily available. Standard bedside equipment for emergency use should include the obturator from the current tube, suction equipment, oxygen, a spare tracheostomy tube of the same size, and one size smaller. Tracheostomy tubes may be either cuffed or uncuffed/ cuffless, the inflated cuff seals the opening around the tube to create a tight fit in the trachea which prevents air leakage and aspiration, and permits mechanical ventilation. Medical record review for Resident 32 was initiated on 4/29/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's Order Summary Report showed the following physician's orders: - dated 4/2/25, for tracheostomy tube, to use Shiley COV8CFD and check cuff PRN for leakage and/or discomfort by the RT. In an emergency, a license nurse may replace tracheostomy if out; and - dated 4/6/25, to change Yankauer suction catheter every night shift every Sunday. a. On 4/29/25 at 1131 hours, Resident 32 was observed in bed with a tracheostomy tube in place and connected to a mechanical ventilator. A set-up bag containing a Yankauer suction hanging on the wire shelf was observed with the date of 4/20/25. On 4/29/25 at 1509 hours, an observation for Resident 32 and concurrent interview was conducted with RN 4. RN 4 verified the set-up bag containing a Yankauer suction hanging on the wire shelf was dated 4/20/25. RN 4 was observed looking into the upper wire shelf and found another set-up bag containing a Yankauer suction, the set-up bag was dated 4/27/25. RN 4 stated the set-up bag with Yankauer suction dated 4/20/25, should have been thrown away. b. On 5/5/25 at 0831 hours, an observation for Resident 32 and concurrent interview was conducted with RCP 1. Resident 32 was observed in bed with a tracheostomy tube in place connecting to a mechanical ventilator. When asked to show the emergency tracheostomy set at Resident 32's bedside, RCP 1 showed an uncuffed, size 7 tracheostomy set. RCP 1 verified the emergency tracheostomy set was uncuffed. RCP 1 stated the tracheostomy set should be cuffed for the residents on a mechanical ventilation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29461 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided for two of 19 final sampled residents (Residents 32 and 72) and two nonsampled residents (Residents 26 and 296) when: * The facility failed to ensure the administration of controlled medication for Resident 296 was documented in the narcotic record. * The facility failed to ensure a record of controlled medications for Residents 26 was completed * The facility failed to ensure Resident 72's old lidocaine external patch (patch used for pain relief) was removed as ordered by the physician. * The facility failed to adhere to Resident 32's blood pressure and blood glucose parameters as prescribed by the physician for two medications: midodrine (blood pressure medication) and insulin (medication to lower blood sugar levels). These failures posed the risk for diversion of the controlled medications and medication errors, and may have negative impact on the residents's health and physical well-being. Findings: Review of the facility's P&P titled Pharmacy Services, Controlled Medications revised 5/2007 showed when a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: - Date and time of administration. - Amount administered. - Signature of the nurse administering the dose, completed after the medication is actually administered. Further review of the policy showed a controlled medication accountability record is prepared when receiving or checking in a Schedule II, III, IV, or V medication. The following information is completed: - Name of the resident. - Prescription number. - Name, strength (if designated), and dosage form of medication. - Date received. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Quantity received. 1. On 4/29/25 at 1530 hours, an inspection of Medication Cart C and interview was conducted with LVN 10. A medication bubble pack labeled with Resident 296's name was observed with 25 tablets of hydrocodone-acetaminophen (controlled medication to relieve pain) 5-325 mg tablet. Review of Resident 296's Narcotic and Hypnotic Record form showed a pharmacy label with a total quantity of 26 tablets. LVN 10 was asked regarding the facility's process when administering a controlled medication. LVN 10 stated the licensed nurses would pull the medication from the supply, sign the narcotic log, and document in the PCC. LVN 10 stated Resident 296's hydrocodone-acetaminophen medication was just delivered, that was the reason why it was not signed out from the narcotic record. When asked what time LVN 10 administered the medication to Resident 296, LVN 10 verified from the PCC that the medication was administered at 1415 hours. Medical record review for Resident 296 was initiated on 4/29/25. Resident 296 was admitted to the facility on [DATE]. Review of Resident 296's Order Summary Report dated 5/5/25, showed a physician's order dated 4/28/25, for hydrocodone-acetaminophen oral tablet 5-325 mg one tablet orally every six hours as needed for moderate pain (pain level of 4-6, using the pain scale of zero to 10, zero for no pain and 10 meaning worst) related to S/P L1-L5 decompression and fusion; and to hold if sedated or for respiratory rate less than 12 breaths per minute (NTE 3000 mg/day of Tylenol medication). Review of the pharmacy Delivery Receipt for Resident 296's hydrocodone-acetaminophen 5-325 mg tablet medication showed a printed date from the pharmacy of 4/29/25; however, there was no documentation of the date and time when it was received. LVN 10 stated it was the ADON who signed for Resident 296's medication. LVN 10 verified the above findings. On 4/29/25 at 1551 hours, an interview and concurrent facility document review was conducted with the ADON. The ADON verified she received the hydrocodone-acetaminophen 5-325 mg for Resident 296 at around 1330 hours. The ADON also verified the delivery receipt was not signed by her because she received a lot of the delivered medications. The ADON stated it should have been dated and timed when received. Review of the pharmacy's Proof of Prescription Delivery for hydrocodone-acetaminophen 5-325 mg medication showed the delivery time of 4/29/25 at 1342 hours, and 26 tablets were received by the ADON. 2. On 5/2/25 at 0910 hours, an interview and inspection of Medication Room A was conducted with LVN 9. During the inspection, a plastic bag containing Resident 26's medications for the family to pick-up was observed. Inside the plastic bag, a medication bubble pack was observed with a label showing Tramadol (controlled medication to relive pain) HCL 50 mg tablet. Nine of one-half tablets were in the bubble pack. The plastic bag also contained non-controlled medications for Resident 26. The Tramadol bubble pack did not have a narcotic count sheet with the medication. LVN 9 verified the findings. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/25 at 0933 hours, an interview was conducted with the ADON for Resident 26. The ADON stated Resident 26's family brought the medications from home and it was the 3-11 shift staff who received the medications from the resident's family member when the resident was admitted . The ADON further stated she did not check the medications herself; however, she had informed the family member the facility would order the medications and informed the incoming shift staff that the medications needed to be returned to Resident 26's family member. On 5/2/25 at 1036 hours, the ADON provided a copy of the Narcotic and Hypnotic Record for Resident 26. The ADON stated RN 7 had a copy of the narcotic count sheet brought in by the family member from the previous admission. The narcotic count sheet showed 14 tablets circled as the total number of tablets when Resident 26 had left the facility; followed by a documentation of nine tablets circled with initial, and six tablets circled with initials crossed out. The ADON verified the findings and stated there should have been a new narcotic sheet started when the medication was received. 49644 3. Review of the facility's P&P titled Transdermal Drug Delivery System (Patch) Application (undated) showed to administer medication through the skin for continuous absorption while the patch is in place, through proper placement of the patch and care of the application sites. The procedures section showed to remove the old patch from the body. On 4/30/25 at 0920 hours, a medication administration observation for Resident 72 was conducted with LVN 1. LVN 1 was observed removing the previous lidocaine (medication used to relieve nerve pain) external patch before applying the new lidocaine external patch 5% on Resident 72's left shoulder. Medical record review for Resident 72 was initiated on 4/30/25. Resident 72 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 72's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 72's Order Summary Report dated 4/26/25, showed a physician's order dated 4/23/25, for lidocaine external patch 5 %, apply to the left shoulder topically one time a day for pain management, on at 0900 hours, off at 2100 hours, and remove per schedule. On 4/30/25 at 0933 hours, an interview was conducted with LVN 1. LVN 1 verified the lidocaine patch was not removed from Resident 72's left shoulder. LVN 1 stated the lidocaine patch should have been removed from Resident 72's left shoulder at 2100 hours, as ordered by the physician. On 5/1/25 at 1419 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the MAR showed the licensed nurse had signed indicating the lidocaine external patch 5 % was removed on 4/29/25 at 2100 hours, from Resident 72's left shoulder. The ADON stated the licensed nurse should have taken the lidocaine external patch out because it was the physician's order. The ADON further stated once a licensed nurse signed, it meant he did it. The ADON stated the licensed nurse should have followed the procedure on proper medication administration. The ADON stated she called Resident 72's physician right away when the nurse informed her about the lidocaine patch was not removed as ordered by the physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/25 at 1353 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated she spoke with the licensed nurse. The DON further stated the licensed nurse assessed the site and said there was no redness and no signs of skin irritation on Resident 72's skin. The DON stated the licensed nurse should have applied the patch and removed as ordered by the physician. 52559 4. Review of the facility's P&P titled Medication Administration revised 8/2021 showed the medications are administered in accordance with the prescribed orders. Medical record review for Resident 32 was initiated on 5/2/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's H&P examination dated 4/3/25, showed Resident 32 did not have the capacity to make medical decisions. Resident 32' had diagnoses including Type 2 DM and hypotension. Review of Resident 32's Order Summary Report showed the following physician's orders: - dated 4/1/25, to administer one midodrine 15 mg tablet via GT every eight hours for hypotension, and to hold the midodrine if the systolic blood pressure was more than 130 mmHg. - dated 4/1/25, to administer insulin regular human injection solution per sliding scale subcutaneously every six hours for diabetes with the following medication parameters: - no insulin for the blood glucose level of 0 to 150 mg/dl, - to inject 2 units of insulin for the blood glucose level of 151 to 200 mg/dl, - to inject 4 units of insulin for the blood glucose level of 201 to 250 mg/dl, - to inject 6 units of insulin for the blood glucose level of 251 to 300 mg/dl, - to inject 8 units of insulin for the blood glucose level of 301 to 350 mg/dl, - to inject 10 units of insulin for the blood glucose level of 351 to 400 mg/dl, - to inject 12 units of insulin for the blood glucose level above 400 mg/dl, and to call the physician. Review of Resident 32's plan of care dated 4/12/25, showed the following: - a care plan for hypotension with interventions including giving medications as ordered and to monitor for side effects. - a care plan for diabetes with interventions including giving diabetes medication as ordered by the physician and to monitor and document side effects. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 32's MAR for April 2025 showed Resident 32 was administered the midodrine medication when Resident 32's blood pressure was above the parameters prescribed by the physician on the following dates: - dated 4/24/25 at 2200 hours, Resident 32's systolic blood pressure was 140 mmHg, - dated 4/26/25 at 1400 hours, Resident 32's systolic blood pressure was 147 mmHg. Review of Resident 32's MAR for April 2025 showed Resident 32 was not administered the insulin medication when Resident 32's blood glucose level on 4/20/25 at 1800 hours was 165 mg/dl. On 5/5/25 at 0924 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 reviewed Resident 32's medical record and verified the above findings. RN 3 stated before the administration of a medication, the licensed staff would document the resident's blood glucose level or blood pressure into the MAR and follow the reminder regarding the medication's parameters populated on the MAR. On 5/5/25 at 1703 hours, an interview was conducted with the DON, Administrator, ADON, and Subacute Clinical Coordinator. The DON, Administrator, ADON, and Subacute Clinical Coordinator were informed and acknowledged the above findings for Resident 32.

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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** 29461 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage, labeling, and disposal of medications. * The facility failed to ensure the expired supply was removed from the medication cart, the medication was labeled, and the supplies were clean and sanitary for Medication Cart A. * The facility failed to ensure the supplies in the cart were kept in clean and sanitary manner and the expired supplies were removed from the current supplies from Medication Cart B. * The facility failed to ensure the internal medications were not mixed with external medications for Medication Cart C. In addition, the facility failed to ensure the non-controlled medication was not stored with the controlled medication inside Medication Cart C. * The facility failed to ensure the expired supplies were removed from the medication and the supplies were kept in clean and sanitary manner for Medication Carts D and E. * The facility failed to ensure an undated can of orange juice was removed from the House Supply Snack Drawer from Medication Room A. * The facility failed to ensure the treatment medications, medical supplies, and breathing treatment supplies were properly secured and stored. Additionally, the facility failed to properly dispose of the expired medications, medical supplies, and breathing treatment supplies. * The facility failed to ensure Medication Cart H was not left unlocked and unattended. * The facility failed to ensure the treatment supplies were not left unsupervised and unattended. * The facility failed to ensure one container of Desitin 13% zinc oxide diaper rash cream and one bottle of Hibiclens chlorhexidine gluconate solution 4.0% (antiseptic skin cleanser) were not left on top of Resident 59's bedside cabinet. These failures posed the potential risk for the residents to receive the expired medications and treatments, and for the unauthorized personnel to have access to unsecured supplies. Findings: Review of the facility's P&P titled Medication Storage and Labeling (undated) showed the following: - All drugs will be labeled and stored in a manner consistent with the manufacturers' published specifications, federal and state regulations, and to enhance accurate and safe medication administration by the facility staff. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- External use drugs in liquid, tablet, capsule or powder form shall be stored separately from drugs for internal use. - Drugs shall be stored in an orderly manner in cabinets, drawers or carts of sufficient size to prevent crowding. - Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use. 1. On 4/29/25 at 1207 hours, an inspection of Medication Cart A and concurrent interview was conducted with RCP 4. The following was observed: - One levalbuterol (medication used for breathing treatment) inhalation solution USP 0.63 mg/3 ml foil package sealed without a label. - One blue tray with plastic medication cups stored with the rim of the plastic cup touching the inner base of the tray. The tray was dusty. - An opened Clorox Bleach Germicidal Wipes with an expiration date of 3/19/25. RCP 4 verified all the above findings. 2. On 4/29/25 at 1437 hours, an inspection of Medication Cart B and concurrent interview was conducted with LVN 7. The following was observed: - A box containing Sureprep Protective Wipes had an expiration date of 12/23/24. - Two single use [NAME] Collagen Powder Sterioles were cut open. - A blue tray storing four boxes of [NAME] Collagen powder had powder residue on the tray. LVN 7 stated she did not know who left it there and did not see the bottom of the tray. - 10 packets of Promogram Prisma (used for management of all wound healing) with an expiration date of 8/31/24, and one packet with an expiration date of 5/22/23. - One Silver Alginate (used to manage wound) dressing 2 x 2 (5 cm x 5 cm). - One opened Curad non-adherent pad. - One blue tray with black residue on the bottom of the tray, containing two sealed Hydrocortisone Cream 1% Cream. LVN 7 stated the black residue was from the dried black Iodine. - One bottle of Betadine solution with dried solution between the cap and the container. - One opened packet of a non-adherent pad 3 x 4 inches. - One Calcium Alginate (used for wound healing) 4 x 4 inches was cut with partial dressing inside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Aquacel AG (silver) Foam (dressing used to absorb wound fluid and provide moist would healing environment) 4 x 4 inches/10 cm x 10 cm with an expiration date of July 2022. - Three Suresite Window Transparent Film Dressing not inside a package. LVN 7 verified all the above findings. 3. On 4/29/25 at 1531 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 10. The following was observed: - two diclofenac sodium gel (used to treat the symptoms of arthritis) 1% were stored with Trelegy Ellipta (an inhaler used for long-term treatment of moderate to severe asthma) - two bisacodyl (medication to treat constipation) 10 mg suppository were stored with six tablets of hyosycamine sulfate (medication to treat stomach ulcers and bladder spasms) 0.125 mg and five tablets of Ondasetron (medication to treat nausea and vomiting) 4 mg medications. - enoxaparin sodium injection (medication to treat blood clots) 100 mg/ml stored with ipratroprium-albuterol (breathing treatment) 0.5-3(2.5) mg/3 ml and Clear Lax powder (laxative for occasional constipation). LVN 10 verified the above findings. 4. a. On 4/30/25 at 1146 hours, an inspection of Medication Cart D and concurrent interview was conducted with the ADON. The following was observed. - One opened IV Start Kit. - One opened Y extension wet with connectors. - One 22 gauge needle expired on 12/31/24. The ADON verified all the above findings. b. On 5/1/25 at 0810 hours, an inspection of Medication Cart E and concurrent interview was conducted with LVN 4. The following was observed: - One opened Medline Optiform Gentle EX silicone faced foam and border (dressing used to help absorb shear force and friction and manage moisture) - One [NAME] Premium Skin Staple Remover Kit [NAME] Syle had an expiration date of 2/2025. LVN 4 verified the above findings. 5. On 5/2/25 at 0910 hours, an inspection of Medication Room A and concurrent interview was conducted with LVN 9. During the inspection, one can of orange juice 213 ml was observed inside the drawer labeled House Supply Snack Drawer. The orange juice did not have an expiration date. LVN 9 verified the findings and stated the orange juice would be thrown away. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32179 6. Review of the facility's P&P titled Medication Access and Storage dated 5/2024 showed the medication storage should be kept clean, well lit and free of clutter. Only the licensed nurses, consultant pharmacist, and those lawfully authorized to administer medications (e.g medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. On 4/29/25 at 1055 hours, an observation was conducted of Closets B and C in Room C. Resident C's closet (Closet C) was open and unsecured with the following items found on the wooden shelves: - Six boxes containing 144 packages of skin protectant ointment (Vitamin A and D) were expired on 1/2022, a total of 864 packets. - One box of Calmoseptine containing menthol and zinc oxide. - 14 tubes of zinc oxide were expired on 4/2021. - 18 bottles of normal saline (500 ml) were expired on 1/3/21. - Two boxes of conforming stretch gauze bandages (sterile) containing 12 packs per box. - One box of ABD pads (5 x 9 inches) containing 20 packs per box. The following items were found in Closet B: - One box of disposable inner cannulas for 7 mm tubes was expired on 10/1/21. - One box of disposable inner cannulas was expired on 7/16/26. - One box of disposable inner cannulas for 9 mm tubes was expired on 5/7/25. - One box of Blue Select tracheostomy inner cannulas (8 mm). - One box of drain sponges non woven (12 trays, 25 pouches per tray). - One box of gauze sponges (compresses, 4 x 4 inches) containing 100 sponges per box. - One box of nonwoven drain sponges. The upper parts of all the boxes were covered in dust and a small piece of wood was observed on top of an open box. A few breathing supplies with open lids were exposed to dust and wood debris. On 4/29/25 at 1400 hours, an interview was conducted with RCP 2. RCP 2 stated he knew the breathing equipment had been stored for a month. RCP 2 explained they used the storage because the central supply area was full. RCP 2 stated the closet did not belong to a resident, and RCP 2 was unaware that the breathing treatment equipment should not be stored in a closet next to a resident's closet inside Room C. RCP 2 would ask another staff if it could not be kept there. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 at 1415 hours, an interview was conducted with LVN 5. LVN 5 stated he was not aware breathing treatments, medical supplies, and treatment medications were stored there. LVN 5 stated the treatment medications should be kept locked in the treatment cart, the medication room, and stored in central supplies. LVN 5 verified the findings. On 4/29/25 at 1430 hours, an interview was conducted with LVN 3. LVN 3 stated she was not aware the breathing treatments, medical supplies, and treatment ointments were stored unlocked in Room C's closet. LVN 3 was informed of the dust, wood piece debris and unsanitary storage for medical, breathing supplies and treatment medication. LVN 3 stated they should be in clean storage, secured, and verified the findings. On 4/29/25 at 1500 hours, an interview was conducted with Subacute Clinical Care Coordinator. The Subacute Clinical Care Coordinator stated all the skin protectant ointments and normal saline should be kept in the central supplies. The Subacute Clinical Care Coordinator stated it was not a usual practice to keep these supplies in a resident's room closet and stated the expired supplies and medications should be thrown away. The Subacute Clinical Care Coordinator was not aware of this and verified the findings. On 4/29/25 at 1535 hours, an interview was conducted with RCP 3. RCP 3 stated during the COVID-19 supply shortage, the staff may have stored items as backup while gradually replenishing supplies and over time may have lost track and forgotten about them. RCP 3 acknowledged the staff might have saved them in case of a future pandemic, but so far, they had never been. RCP 3 also acknowledged the potential for the visitors or other staff to access the supplies and stated they should be kept in the central supplies and breathing treatment supplies room. On 4/30/25 at 1000 hours, an interview was conducted with the Central Supplies Staff. The Central Supplies Staff stated she was not aware medical, breathing, and treatment supplies had been stored in a resident's closet. The Central Supplies Staff explained when the supplies arrive, they would be taken straight to the central supply and were distributed to the staff who needed them. On 4/30/25 at 1140 hours, an interview was conducted with the DON. The DON stated she was not aware of the situation and stated if she had known, she would not have allowed it to happen and would have relocated the supplies. The DON verified the findings. 39453 7. On 5/5/25 at 1317 hours, Medication Cart H was observed unlocked, unattended, and parked in front of the wall near Room D facing the hallway. On 5/5/25 at 1319 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 2. LVN 2 verified Medication Cart A was unlocked and unattended. 8. On 5/5/25 at 0931 hours, a wound care treatment and catheter care observation for Resident 32, and a concurrent interview was conducted with LVN 4. The following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LVN 4 was observed preparing the treatment supplies for Resident 32, and placed the surgical sponges, T-drain sponges, xeroform, normal saline in single-use vials, and a Therahoney wound gel (a sterile, medical-grade Manuka honey dressing used to treat a variety of wounds, including burns, cuts, and chronic wounds) on a bedside table; - CNA 3 was observed assisting Resident 32 with turning and repositioning; - LVN 4 was observed pushing the bedside table with the treatment supplies near Resident 32's bed. Then, LVN 4 was observed with the resident's basin and going to the resident's bathroom. - LVN 4 was observed leaving the treatment supplies unattended and unsupervised. CNA 3 was observed with Resident 32, and there were two other CNAs observed inside the room with another resident. - During the wound care, LVN 4 was observed going to the door, taking out his gown and washed hands in the bathroom, and leaving the treatment supplies unattended and unsupervised. On 5/5/25 at 0944 hours, a follow-up interview was conducted with LVN 4. LVN 4 verified he left the treatment supplies near Resident 32's bed unattended and unsupervised. LVN 4 stated, it is okay to leave the treatment supplies, as long as there is another staff there. That has been our practice here. 49644 9. Review of the facility's P&P titled Medication Storage and Labeling (undated) showed the storage of nonlegend drugs at the bedside shall meet the following conditions: - The manner of storage shall prevent access by other patients. Lockable drawers or cabinets need not be used unless alternate procedures, including storage on a patient's person or in an unlocked drawer or cabinet are ineffective. - The facility shall record in the patient health record the bedside medications used by the patient, based on observation by nursing personnel and/or information supplied by the patient. - The quantity of each drug supplied to the patient for bedside storage shall be recorded in the health record each time the drug is supplied. On 4/29/25 at 1120 hours, during the initial tour of the facility, Resident 59 was observed lying in bed with eyes closed. One container of Desitin 13% zinc oxide diaper rash cream and one bottle of Hibiclens chlorhexidine gluconate solution 4.0% (antiseptic skin cleanser) was observed on top of Resident 59's bedside cabinet. Medical record review for Resident 59 was initiated on 4/29/25. Resident 59 was admitted to the facility on [DATE]. Review of Resident 59's Physician Note dated 6/9/24, showed the resident was non-verbal and unable to follow verbal commands. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 at 1425 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified one container of Desitin 13% zinc oxide diaper rash cream and one bottle of Hibiclens chlorhexidine gluconate solution 4.0% (antiseptic skin cleanser) were on top of Resident 59's bedside cabinet. LVN 2 stated Resident 59's family provided the medications. LVN 2 stated the facility's staff told Resident 59's family member to let the nurse know if they would bring something and to let the treatment nurse know what the medication was for. On 5/2/25 at 1406 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the facility's staff including the licensed nurse, RT, and CNA checked the residents' bedside on every shift basis to ensure no medications at the residents' bedside. The DON further stated the family visited Resident 59 regularly and the facility's staff did not know if they brought something. The DON stated the facility's staff always educated the residents' family to let them know if they would bring medication so they could get an order from the physician.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 35346 Based on observation, interview, and facility document review, the facility failed to follow the menu for nine residents who were on pureed diets. * The facility failed to ensure the pureed potato recipe was followed during the pureed food preparation. This failure had the potential of not following the menu and not meeting the residents' nutritional needs which could lead to nutritional-related health complications. Findings: Review of the April 2025 Diet Type Report for the residents on puree diets showed a total of nine residents received the puree meals prepared in the facility's kitchen. Further review of this document showed two residents were on no added salt puree diets. On 4/30/25 at 1040 hours, a puree food preparation observation was conducted with [NAME] 1. [NAME] 1 was observed adding low sodium broth to the puree potatoes being prepared for the residents on puree diets. However, review of the facility's recipe for puree potatoes showed to gradually add warm milk to the pureed potatoes. The finding was verified with [NAME] 1.

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F 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35346 Based on observation, interview, and facility document review, the facility failed to ensure the food prepared in the facility's kitchen was attractive in appearance and at an appetizing temperature. This failure had the potential for the residents to not eat the food served and could affect their nutritional status. Findings: According to the IDDSI.org website, puree food items have a smooth texture with no lumps. Review of the April 2025 Diet Type Report for the residents on puree diets showed a total of nine residents received the pureed meals prepared in the facility's kitchen. On 4/30/25 at 1040 hours, a puree preparation observation was conducted with [NAME] 1. [NAME] 1 was observed preparing the puree salad. The prepared puree salad had lumps and with water surrounding the puree salad. When asked what consistency the puree salad should be, [NAME] 1 stated it should be apple sauce consistency. When asked about the lumps and water surrounding the puree salad, [NAME] 1 stated when the salad cooled down, the consistency would look more like apple sauce consistency. On 4/30/25 at 1135 hours, a trayline observation was conducted with the Food and Nutrition Services Director. When asked about the lumps and water surrounding the puree salad, the Food and Nutrition Services Director was not able to explain. When asked about the temperature of the puree salad, the Food and Nutrition Services Director stated it was 60 degrees F. The Food and Nutrition Services Director was informed the puree salad was not attractive in appearance and was not at an appetizing temperature. The Food and Nutrition Services Director verbalized the salad would be cooled down to a lower temperature. On 5/1/25 at 0830 hours, a concurrent interview and facility document review was conducted the Food and Nutrition Services Director. When asked about documenting the temperature after the puree salad was cooled down, the Food and Nutrition Services Director verified the temperature was not documented on the food temperature log.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met. * A red bucket solution was stored next to the food items. * There was a staff portable radio stored on the beverage preparation area. * Two soft, wrinkled, and blackened bell peppers were stored inside the refrigerator. * A bag of croissants opened [DATE], was stored inside the refrigerator. * There was a staff water bottle stored inside walk in refrigerator. * There was an unlabeled package of mushrooms in the refrigerator. * There was an unlabeled frozen pizza and unlabeled bag of tamales. These failures posed the risk of unsanitary and possible food-borne illness. Findings: Review of the Diet Type Report dated [DATE], showed 59 of 95 residents food were prepared in the kitchen. Review of the facility's P&P titled Storage of Food and Supplies dated 2023 showed the food storage areas should be used only for food. The cleaning supplies should be stored in entirely separate and specific areas. Review of the facility's P&P titled Refrigerator and Freezer dated 2023 showed all the foods were to be checked weekly for expiration and use by dates. On [DATE] at 1040 hours, a tour of the facility's kitchen and interview was conducted with the Food & Nutrition Services Director. The Food & Nutrition Services Director showed a total of 59 of 95 residents residing in the facility received food prepared in the kitchen. The following observations were verified with the Food & Nutrition Services Director: - A station with two counters was observed inside the kitchen. When asked what the station was used for, the Food & Nutrition Services Director verbalized the station was used to prepare beverages for the residents and store barrels of food items. A staff portable radio was observed on the top counter of this station. On the bottom counter of this station, an uncovered red bucket containing sanitizing solution was observed stored next to barrels containing sugar and food thickener. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Two bell peppers with soft, wrinkled, and blackened area on the peppers' outer surfaces were observed stored inside the facility's refrigerator. - A bag of croissants with open date [DATE], was observed stored inside the refrigerator. When asked how long these items could be kept in the refrigerator, the Food & Nutrition Services Director stated they could be kept for up to seven days from the open date. - A package of unlabeled mushrooms was stored inside the refrigerator. When asked how long this food item could be kept, the Food & Nutrition Services Director said up to seven days from purchase date. However, the package did not have a purchase date on it and the Food & Nutrition Services Director was unable to state when the package was bought. - A staff's personal water bottle was observed stored on the floor, underneath the ready to eat fruit, inside the walk-in refrigerator. - A frozen pizza with expiration date [DATE], was stored in a Smart & Final plastic bag, inside the walk-in freezer. - A bag of tamales unlabeled was stored in a Smart & Final plastic bag, inside the walk-in freezer. The Food & Nutrition Services Director was unable to state when the items were bought or when they expired. The Food & Nutrition Services Director verified the above findings.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 48332 Based on interview, medical record review, and facility document review, the facility failed to ensure the medical record for one of three final sampled residents (Resident 8) reviewed for closed records was complete. * There was inconsistent documentation of Resident 8's monitoring for the indwelling urinary catheter care and checking of Quinton catheter (a type of central venous catheter inserted on the chest wall used for hemodialysis access when the conventional vascular access is difficult to establish) to the right upper chest wall. This failure had the potential for Resident 8's care needs to not be met as there were missing documentation in the medical record. Findings: Review of the facility's document titled Documentation Content of the Record Set (undated) showed under Federal Regulations Pertaining to Clinical Records: Federal regulation requires that the facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. Closed medical record review for Resident 8 was conducted on 5/2/25. Resident 8 was admitted on [DATE], readmitted on [DATE], and discharged on [DATE]. Resident 8's diagnoses included End Stage Renal (kidney) Disease, Dependence on Renal Dialysis (life sustaining procedure used to treat kidney failure by filtering the blood and removing waste products and excess fluid when the kidneys are not able to do so naturally), Obstructive (blockade) and Reflux Uropathy (condition where urine flows backward from the bladder into the ureters and sometimes the kidneys), Encounter for fitting and adjustment of urinary device (Foley catheter, a flexible tube inserted into the bladder through urethra to drain urine from the bladder). Review of Resident 8's Order Summary Report dated 5/2/25, showed an order dated 4/8/25, for indwelling urinary catheter care with soap and water every shift, and check Quinton catheter to the right upper chest wall for bleeding, bruising, signs and symptoms of infection, and call MD PRN every shift. Review of Resident 8's plans of care showed the following care plans: - dated 4/8/25, for the needs of dialysis related to renal failure. Interventions included to check and change dressing daily at access site; document/monitor/report to MD PRN any signs and symptoms of infection to access site: redness, swelling, warmth or drainage; and monitor/document/report to MD PRN for signs and symptoms of the following: bleeding, hemorrhage, bacteremia, and septic shock. - dated 4/8/25, risk for infection, presence of Foley Catheter. Interventions included to monitor for signs/symptoms of infection Review of Resident 8's TAR for April 2025 showed the following: (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- The entry to check Quinton catheter to right upper chest wall for bleeding, bruising, signs and symptoms of infection, call MD PRN. There was no nursing documentation on 4/12 and 4/15/25, for the PM shifts for the Quinton catheter check as ordered. - The entry for the indwelling urinary catheter care with soap and water every shift. There was no nursing documentation on 4/12 and 4/15/25, for the PM shifts. The catheter care was provided. On 5/5/25 at 1010 hours, an interview and concurrent medical record review of Resident 8's TAR was conducted with LVN 7. LVN 7 verified the above missing documentation. LVN 7 stated if the TAR was blank, it was because it was not done or the staff forgot to document. On 5/5/25 at 1015 hours, an interview and concurrent medical record review of Resident 8's TAR was conducted with the ADON. The ADON verified the missing documentation in the TAR on the evening shifts and stated it could have been done but forgot to sign.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for March 2025. The facility failed to document the actual onset of the signs and symptoms of infection when the IP documented the date of the onset of the signs and symptoms, same as the date of the start of the antibiotics. The facility failed to correctly classify HAIs and CAIs when the IP classified it based on the use of antibiotics, whether recurring, prophylactic or maintenance, and not on the date of the onset of the signs and symptoms of infection. * The facility failed to ensure the IP surveillance log matched the data in their surveillance screening. * The facility failed to ensure the monthly mapping of infections included all the infections, including the specific microorganism of the infection. * The facility failed to ensure the clean linen was stored in the sanitary condition. * The facility failed to ensure Resident 32's indwelling urinary catheter bag and tubing did not touch the floor. * The closets in Rooms A, B, and C contained the residents' diapers, gowns, and linens which were stored in the unsanitary condition. * Resident 6's urinary catheter privacy bag dragged across the floor. * The facility failed to follow the EBP for Resident 46's perma-catheter for hemodialysis use. These failures posed the risk of not identifying the residents' infections and controlling the potential transmission of communicable disease to other residents throughout the facility. Findings: 1. According to the Epidemiology of Community-Acquired and Nosocomial Infections by [NAME] and [NAME], published in the International Journal of Medical Microbiology, in 2013 showed any infection occurring within the first 48 hours of hospitalization is considered community-acquired while any infection occurring after 48 hours is considered nosocomial. Review of the facility's P&P titled Surveillance for Infections revised 9/2017 showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The IP will conduct ongoing surveillance for HAIs and other epidemiologically significant infections that have a substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions; and - The purpose of the surveillance of infection is to identify both individual cases and trends of epidemiologically significant organisms and HAIs to guide appropriate interventions and to prevent future infections. On 5/1/25 at 1054 hours, a concurrent interview, medical record review, and facility document review was conducted with the IP. The IP was asked to show the facility's infection control surveillance program for March 2025. Review of the facility's documented titled Infection Prevention and Control Surveillance Log for Subacute for March 2025 showed there were 10 residents listed on the log. Review of the facility's documented titled Infection Prevention and Control Surveillance Log for South Station for March 2025 showed there were 15 residents listed on the log. a. Further review of the facility's surveillance logs showed the onset date was the same as the start date of the antibiotic for all the residents listed on the log. For example: * For Resident 59, the onset date and start date of antibiotic was documented as 3/2/25. * For Resident 70, the onset date and start date of antibiotic was documented as 3/1/25. The IP verified the above findings. The IP stated the onset date meant the onset of the signs and symptoms of infections, and she documented the onset date same as the start date of the infections because she usually just type the onset date same as the start date of the antibiotic. However, when asked to show documentation for the onset of the signs and symptoms for Resident 59, the IP was not able to show documented evidence when the signs and symptoms of infection were initially reported. When asked to show documentation for the onset of the signs and symptoms for Resident 70, the IP showed the Infection Prevention and Control Surveillance Log for Subacute for February 2025 showing Resident 70's onset date was 2/28/25. When asked to show documented evidence of when the signs and symptoms of infection were initially reported in March 2025, the IP was not able to show documented evidence of when the signs and symptoms of infection initially reported. The IP stated she made an error when she documented the onset date for Resident 70 was 3/1/25. b. Review of the facility's surveillance logs showed some of the infections were not classified as CAI nor HAIs but were marked as R (recurrent), M (maintenance), or P (prophylactic). For example: * For Resident 58, the resident's infection was not classified as CAI or HAI, and was marked R. The IP verified the above findings. When asked why Resident 58's infection was not classified as CAI or HAI, the IP stated Resident 58 had a recurring infection, and he was classified as CAI the previous month. When asked to show documentation when Resident 58's infection was classified as CAI, the IP looked at the Infection Prevention and Control Surveillance Log for Subacute for February 2025 but was not able to show when Resident 58's infection was categorized as CAI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked about the criteria the facility used to identify and track the HAIs, the IP stated they used the Revised McGeer Criteria and the Infection Screening Evaluation form electronically which would automatically show the criteria analysis. c. Review of the resident's Infection Screening Evaluations forms did not match the signs and symptoms listed in the surveillance log. For example: * For Resident 74, review of the surveillance log for March 2025 showed the resident had dark urine, pain, and scant amount; and the result was bacteriuria. Review of Resident 74's Infection Screening Evaluation dated 3/12/25, showed the resident had an abdominal pain/ tenderness, and no other symptoms. The infection analysis showed the McGeer's criteria were met for gastroenteritis. * For Resident 88, review of the surveillance log for March 2025 showed the resident had increased GT residual, emesis, and low temperature; and the result was leukocytosis. Review of Resident 88's Infection Screening Evaluation dated 3/18/25, showed the resident's single temperature of more than 100 F, pulse of more than 100 beats per minute, and abdominal pain/tenderness. The infection analysis showed the McGeer's Criteria was met for gastroenteritis. * For Resident 21, review of the surveillance log for March 2025 showed the resident had dark urine, frequent urination, and dysuria; and the result was P. mirabilis in urine. Review of Resident 21's Infection Screening Evaluation form dated 3/8/25, showed the resident had urinary frequency; however, the infection analysis was blank. * For Resident 87, review of the surveillance log for March 2025 showed the resident had a cough, shortness of breath, and thick sputum; and the result was Pneumonia. * Review of Resident 87's Infection Screening Evaluation dated 3/6/25, showed the resident's pulse oximetry was less than or equal to 94% on room air; however, the infection analysis was blank. The IP verified the above findings. The IP stated the RNs documented their resident assessments to the infection screening evaluations forms, while she documented her own resident assessments to the surveillance logs. The IP verified the infection screening evaluations forms did not match the surveillance logs. d. Review of the facility's mapping of infections for March 2025 did now show all the current infections for the month. For example, the following residents with infections were not included in the map: * Resident 70 in Room A, bed A, with colitis; * Resident 59 in Room E, bed C, with Gram positive cocci and folliculitis; * Resident 58 in Room C, bed A, with ESBL, P. Mirabilis in urine; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Resident 38 in Room A, bed B, with nephrolithiasis; * Resident 69 in Room F, bed A, with wound infection; * Resident 97 in Room G, bed B, with C-diff; and * Resident 34 in Room H, bed B, with Pneumonia. The IP verified the above findings. The IP stated she only included the infections classified as CAIs and HAIs and did not include those residents with recurring, prophylactic and maintenance use of antibiotics. The IP stated she used the map to know where the infections were and to consolidate the infections. The IP verified the facility mapping of infections did not reflect the actual resident infections in the facility. The facility failed to ensure the monthly mapping of infections included all the infections, including the specific microorganism of the infection. 2. On 4/30/25 at 0909 hours, an inspection of the laundry area and concurrent interview was conducted with the Maintenance Director/ EVS Laundry Manager. The following was observed in the clean area of the laundry room: - A set of keys was observed on the clean linen folding table, near the cloth isolation gowns; - A water bottle was observed on the bottom shelf of the clean linen folding table, near the blankets; - A cart containing clean curtains was observed not fully covered; - A box of emergency kit and a bag of cleaning supplies were observed stored with the green curtains, stored near the Maintenance Director/ EVS Laundry Manager's office. The Maintenance Director/EVS Laundry Manager verified the above findings. 3. Medical record review for Resident 32 was initiated on 4/29/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's Order Summary Report showed a physician's order dated 4/1/25, for an indwelling urianry catheter size #16 Fr with 10 cc to gravity drainage bag for wound management. On 4/30/25 at 1114 and 1120 hours, Resident 32 was observed in bed, and asleep. Resident 32's indwelling urinary catheter bag and tubing were observed touching the floor. On 4/30/25 at 1125 hours, an observation for Resident 32 and a concurrent interview was conducted with RN 2. RN 2 verified Resident 32's indwelling urinary catheter bag and tubing were observed touching the floor, and not on the basin that was near the catheter bag. 32179 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.a. On 4/29/25 at 1100 hours, Room A's resident closet contained a disposable brief stored on the floor, exposed, unwrapped, and touching the shoe box and splint. The resident's diaper was disorganized. Linen was placed underneath the chair leg, and the diaper was exposed and lying on the floor of the closet. On 4/29/25 at 1400 hours, an observation and concurrent interview was conducted with LVN 11. LVN 11 verified the above findings and stated the staff should have organized and cleaned the residents' closet. LVN 11 acknowledged the potential for contamination as the diaper, gown, and linen were touching the floor and chair legs. b. On 4/29/25 at 1055 hours, Room C's resident closet had a wheelchair cushion stored on the floor of the closet. The cushion was dusty and had small pieces of wood debris. On 4/29/25 at 1130 hours, Room C's resident closet for Resident 63 contained an exposed diaper and the belt gait and clothing were disorganized On 4/29/25 at 1135 hours, Room C's resident closet for Resident 58 contained an exposed diaper was exposed and touching the leg boot. The gown, linen, and towel were disorganized. On 4/29/25 at 1430 hours, an interview was conducted with LVN 3. LVN 3 stated the residents' belongings stored in the closets should be neat and organized, and the diapers should be stored clean. LVN 3 acknowledged the potential for contamination. 3. On 4/29/25 at 1110 hours, Room B's resident closet contained an exposed disposable brief, the gown and linen sheets were disorganized and stored on the floor of the closet, a diaper was stored on the floor, and a leg splint was placed above the diaper. On 4/29/25 at 1405 hours, an observation and concurrent interview was conducted with LVN 11. LVN 11 verified the above findings and stated the staff should have organized and cleaned the residents' closet. LVN 11 acknowledged the potential for contamination of the gown, linen sheets, and diaper. LVN 11 verified the findings. 35346 5. On 4/29/25 at 1623 hours, a concurrent interview and observation was conducted with RN 6. When asked where Resident 6 was, RN 6 showed Resident 6 was up in his wheelchair in the activities room. Resident 6's urinary catheter privacy bag was observed touching the floor. When RN 6 pushed Resident 6's wheelchair across the activities room, Resident 6's urinary catheter bag was observed dragging across the floor. The finding was verified with RN 6. On 4/29/25, medical record review for Resident 6 was initiated. Resident 6 was readmitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 3/24/25, showed Resident 6's diagnoses included post status urinary catheter for urinary retention, post status sepsis, and recurrent UTIs. Resident 6 had no capacity to understand and make decisions. (continued on next page)

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	055575	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's care plan for urinary catheter dated 4/28/25, showed the interventions including minimize the microorganism transmission. 50953 6. Review of the facility's P&P titled EBP revised 6/2024, showed it is the policy of this facility to implement EBP for the prevention of transmission of MDROs. EBP are an infection control intervention designed to reduce transmission of MDROs in a nursing homes. - EBP involve gown and glove are use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices. - Indwelling medical devices would include, but are not limited to, central vascular lines (including hemodialysis catheters), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. Medical record review for Resident 46 was initiated on 4/29/25. Resident 46 was admitted to the facility on [DATE]. Review of Resident 46's Order Summary Report dated 5/1/25, failed to show an order for EBP for the use of the permacatheter to left upper chest wall. On 4/29/25 at 1505 hours, during an observation, Resident 46 was observed with a permacatheter on the left upper chest wall. On 5/5/25 at 0849 hours, an interview and concurrent medical record review was conducted with ADON. The ADON verified Resident 46 has a perma-catheter on the left upper chest wall for her catheter use and failed to have an order for EBP for the use of the permacatheter.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 29461 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the resident care equipment and refrigerator were maintained in the safe operation condition when: * The record of quality control for one glucometer from Medication Cart C was not accurate. * The facility staff used whiteout to correct documentation entries in the Quality Control Record for Glucometers A and B. The facility was not able to refer to the previous entries made as a result of completely erasing the original documentation requiring corrections. * The refrigerator inside Medication Room A containing medications was not kept within the acceptable temperature parameters. * The walk-in freezer inside the kitchen remained free of ice buildup. These failures had the potential to affect care and services provided to the residents in the facility. Findings: 1. Review of the facility's document titled Policy: Quality Control Testing on Assure Platinum Meter showed quality control testing using the Assure Dose Control Solution will be performed to examine the performance of the Assure Platinum Blood Glucose Monitoring System. The Assure Dose Control Solution checks if the meter and test strips are working correctly as a system and if you are testing correctly. a. On 4/29/25 at 1521 hours, an interview and concurrent inspection of Medication Cart C was conducted with LVN 10. One glucometer was observed inside the the drawer. The bottle of Assure Platinum Blood Glucose Strips with Lot # 6338750 was observed with an open date of 4/23/25, with the following reference ranges: - Level 1: 85-107 mg/dl (Normal Control) - Level 2: 214-266 mg/dl (High Control) Review of the Quality Control Record dated April 2025 showed the Test Strip Lot # 6338750 was used from 4/23 to 4/29/25 to check the glucometer. The Normal and High Control result on the following dates showed: - dated 4/23/25, normal control result = 95 mg/dl and high control result = 239 mg/dl - dated 4/24/25, normal control result = 93 mg/dl and high control result = 236 mg/dl - dated 4/25/25, normal control result = 96 mg/dl and high control result = 243 mg/dl (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 4/26/25, normal control result = 94 mg/dl and high control result = 238 mg/dl - dated 4/27/25, normal control result = 90 mg/dl and high control result = 215 mg/dl - dated 4/28/25, normal control result = 91 mg/dl and high control result = 241 mg/dl - dated 4/29/25, normal control result = 94 mg/dl and high control result = 239 mg/dl The record showed the normal and high control results were within range. However, further review of the quality control log record showed the documented normal control and high control were inconsistent with the normal and high control on the bottle. The documentation on the log showed from 4/23 to 4/29/25, the control results were 87-107 mg/dl (Normal Control) and 214-265 mg/dl (High Control), instead of 85-107 mg/dl (Normal Control) and 214-266 mg/dl (High Control). The reference ranges from the bottle of Assure Platinum Blood Glucose Strips did not match the reference ranges documented on the Quality Control Record for the glucometer from Medication Cart C. LVN 10 was asked regarding the facility's process for quality control for the glucometers. LVN 10 stated it was the night shift licensed nurse who was responsible for doing the quality control; however, the licensed nurses were to conduct quality control if a discrepancy was noted on the ranges, if the resident's blood sugar result was not within the normal range for the resident, and when the new bottle of strips was opened. LVN 10 acknowledged and verified the above findings. b. According to CMS guidelines for amending medical records, emphasize the need for clear, permanent identification of amendments, corrections, or delayed entries, along with the date and author of those changes. The original content must remain legible, whether in paper or electronic format, and amendments should be clearly identified as such, with the date and author indicated. The original content should remain readable, even if a change is made. This usually involves drawing a single line through the original text rather than overwiring it, according to Medicare website. The original information should not be completely deleted or removed from the record. According to the Nursing 2025 article: Handling documentation errors, do not obliterate the mistaken entry. Never use correction fluid, black marker, tape, or scratch-out techniques that hide a documation error, or a lawyer could argue that you had something to cover up. Make the correction in a way that preserves the original entry. Draw a single line through the erroneous entry and write the time, date, and your name. On 4/30/25 at 0838 hours, a review of Quality Control Record for Glucometer A was conducted. The entries for 4/30/25, included the Station/Shift, Nurses Initial, Meter Cleaned and Disinfected, Test Strip Lot #, Test Strip Expiration Date, Test Solution Normal 1 Lot #, Expiration Date, Normal Control Range, Normal Control Result, Test Solution High 2 Lot #, Expiration Date, High Control Range, High Control Result, and High Corrective Action. A Quality Control Record form for Glucometer Record was noted with X marks from 4/1-4/29/25. Entries were written for 4/30/25, corresponding to the information to document on the form, from the titles listed. On the column titled Normal Control Result, with the result documented as 90 mg/dl, showed a whiteout correction was used on the form. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Quality Control Record for Glucometer B was also conducted. The entries for 4/30/25, included the Station/Shift, Nurses Initial, Meter Cleaned and Disinfected, Test Strip Lot #, Test Strip Expiration Date, Test Solution Normal 1 Lot #, Expiration Date, Normal Control Range, Normal Control Result, Test Solution High 2 Lot #, Expiration Date, High Control Range, High Control Result, and High Corrective Action. Entries were written for 4/30/25, corresponding to the information to document on the form, from the titles listed. On the columns titled Test Solution Normal 1 Lot #, Expiration Date, Normal Control Range, Test Solution High 2 Lot #, and Expiration date, showed whiteout corrections were used on the form. On 4/30/25 at 0854 hours, an interview and concurrent Quality Control Record review for Glucometers A and B was conducted with the ADON. The ADON stated the normal process for making a correction was the need to check accurately before writing the information, put error, initial, and put the accurate information. The ADON stated she agreed it was not supposed to have whiteout on the document. The ADON further stated the night RN was new; however, the night RN was aware that whiteout should not be used. On 4/30/25 at 0901 hours, an interview and concurrent Quality Control Record review for Glucometers A and B was conducted with the DON. The DON was informed of the findings. The DON acknowledged and stated the facility's process was to cross out the error, document error, and document the correct information. 2. Review of the facility's P&P titled Temperature Control, undated, showed drugs requiring refrigeration shall be store in a refrigerator between 2 degrees C (36 degrees F) and 8 degrees C (46 degrees F). A daily medication refrigerator temperature log will be kept to assure that the temperature is maintained. Twice a day temperature log is required for vaccine storage. Adjustments are made to the thermostatic control as needed. Review of the facility's Temperature Log Sheet for Medication Room A showed the temperature of the refrigerator must maintain: 36-41 degrees F or below. Temperatures were taken twice a day at 0900 and 2100 hours. On 5/2/25 at 0910 hours, an interview and concurrent inspection of Medication Room A was conducted with LVN 9. LVN 9 verified the refrigerator temperatures were taken twice a day. Review of the refrigerator temperature dated 5/2/25 at 0900 hours, showed a temperature reading of 38 degrees F. On 5/2/25 at 0957 hours, the refrigerator temperature was checked and noted at 46 degrees F. The refrigerator contained an e-kit with Humulin R and N (regular and long acting insulin-medication to lower blood sugar), Insulin Lispro, and Insulin Aspart (medications to lower blood sugar levels), Epogen (medication to treat anemia) 10,00 units/ml x 3 vials; Xalatan/Latanoprost (medication to treat high eye pressure with open-angle glaucoma or ocular hypertension) 0.005% eye drops; Tuberculin Purified Protein Derivative Diluted Aplisol (a substance used in a skin test to help diagnose tuberculosis infection); a blue tray containing unopened insulin pen/insulin vial which was wet. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/25 at 1008 hours, during an observation and concurrent interview with LVN 9, the refrigerator temperature was rechecked and noted at 48 degrees F. The inside of the refrigerator was observed with condensation. LVN 9 stated she needed to notify the supervisor and the maintenance because it could affect the composition of the medication. On 5/2/25 at 1017 hours, during an observation and concurrent interview with LVN 9, the refrigerator temperature was rechecked and noted at 50 degrees F. LVN 9 acknowledged and verified the findings. 35346 3. On 4/29/25 at 1045 hours, a tour of the kitchen was conducted with the Food and Nutrition Services Director. Ice buildup was observed along the inner door frame of the walk-in freezer's door. Also, a clear plastic food storage bin was observed with ice buildup on the outer sides of the bin. The finding was verified with the Food and Nutrition Services Director. On 5/1/25 at 0830 hours, a concurrent observation and interview was conducted with the Food and Nutrition Services Director. The walk-in freezer inside the facility's kitchen was observed with ice buildup along the door frame. Inaddition, two clear plastic storage bins were observed with ice buildup along the outer sides of the bins. The findings were verified with the Food and Nutrition Services Director.