STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055645	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Skilled Nursing & Subacute Center	410 North Winchester Boulevard Santa Clara, CA 95050

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44577 Based on interview and record review, the facility failed to revise the care plan for two of 15 residents (Resident 34 & 74) when there was no evidence the facility reviewed or revised the care plan with new recommendations to prevent the Resident from falling again. This failure had the potential to result in further falls and/or injury. Findings: 1. During a review of Resident 34's Fall Report Incident dated 2/21/25, it indicated Resident 34 had a fall on 2/21/25 at 4:30 p.m. During a review of Resident 34's care plans, dated 11/25/24 last revision, indicated no care plan following the 2/21/25 fall or revisions to the previous care plan. During an interview on 5/8/25 at 1:31 p.m. with the Director of Nursing (DON), she stated, the care plan was not updated after the fall. Review of the facility's policy and procedure titled, Fall Prevention and Response, dated 8/2023, indicated Facility will monitor effectiveness of planned fall prevention interventions no less often than quarterly and modify interventions when necessary, such as following a significant COC or fall accident. Review of the facility's policy and procedure titled, Care plan, Comprehensive, dated 2008, indicated It is reviewed and revised by the Interdisciplinary Team quarterly, following completion of the MDS assessment, and following assessment for significant change. Review of the facility's policy and procedure titled, Fall Risk assessment dated [DATE], indicated Monitor the effectiveness of the care plan interventions, and modify the interventions as necessary, in accordance with current standards of practice. 46939 2. During a review of Resident 74's Fall Report Incident dated 1/12/25, indicated Resident 74 had a fall on 1/12/25 at around 7:40 a.m. (continued on next page)

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 74's care plan dated 5/8/25, it indicated, no care plan for Resident 74's fall on 1/12/25. During an interview on 5/8/25, at 3:47 p.m., with Director of Nursing (DON), DON stated, they did not update the care plan for Resident 74's fall on 1/12/25. During a review of the facility's policy & procedure (P&P) titled, Care Plan, Comprehensive dated 2008, the P&P indicated, It is the policy of the facility to develop, in conjunction with the resident and/or representative, the Comprehensive Resident Care Plan.It is completed.following assessment for significant change.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview and record review, the facility failed to ensure services were provided to prevent and/or heal pressure ulcers (damage to the skin or underlying tissue as a result of prolonged pressure) for one of eight sampled residents (Resident 308) with pressureulcers when staff did not follow physician's order for heel protectors (device applied to the feet to minimize pressure on the heels). This failure had the potential to result in worsening of resdient 308's pressure ulcers. Findings: Review of Resident 308's clinical record indicated he was admitted on [DATE] with diagnoses including heart failure (a condition in which the heart doesn't pump blood as well as it should), pancytopenia (abnormally low amounts of all three types of blood cells, red, white and platelets), encephalopathy (disease that affects brain function), and muscle weakness. Review of Resident 308's clinical record indicated a physician order for right and left heel skin barrier film as needed every shift for pressure ulcers. Further review of Resident 308's clinical record indicated a physician order dated 4/26/25, to apply protective boots every evening and night shift for protection while in bed every shift, and on 5/7/25 an order to apply protective boots to both feet every shift. Review of Resident 308's Skin and Wound Evaluation dated 4/25/25 indicated Resident 308's skin was fragile and at risk for skin breakdown. Review of Resident 308s Braden Scale for Predicting Pressure Score Risk dated 4/24/25 indicated a score of 17 (At Risk 15-18), and potential problem with friction and shear (gradual breakdown of the skin from constant rubbing against something and forces that cause body tissues or parts to move in opposite directions) due to weak movement or requiring assistance and skin sliding to some extent against sheets or other devices. Review of Resident 308's Care Plan Report dated 4/25/25 indicated Resident 308 had a new impairment to skin integrity with interventions including, Treatment per order. During observations on 5/5/25 at 9:26 a.m., 5/6/25 at 8:30 a.m., and 5/8/25 at 4:10 p.m., Resident 308 was lying in bed and was not wearing heal protectors on both feet. During a concurrent observation, interview and record review on 5/6/25 at 9:18 a.m., with Licensed Vocational Nurse C (LVN C) during wound care for Resident 308, LVN C stated Resident 308 had stage 1 pressure ulcers to the heels of both feet. LVN C confirmed there was a physician order for bilateral heel protective boots and stated Resident 308 was not wearing any heel protective boots while in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/6/25 at 2:15 p.m., with Certified Nursing Assistant E (CNA E), CNA E confirmed Resident 308 was not wearing bilateral heel protector boots while in bed. CNA E looked for Resident 308's heel protectors inside the room, inside the closet and in each of Resident 308's drawers. CNA E stated the boots could not be found. During a concurrent interview and record review on 5/8/2023 at 3:30 p.m., with the Director of Nursing (DON), the DON reviewed Resident 308's Order Summary Report and care plan. The DON confirmed the physician's order for bilateral heel protectors on 4/26/2025 and 5/7/25, and stated the heel protector boots must be somewhere in Resident 308's room and should be on his feet while he's in bed. Review of the facility's policy and procedure titled, Pressure Injury Prevention and Management, revised 12/03/2024, indicated, This facility is committed to the prevention of avoidable pressure injuries . and to provide treatment and services to heal the pressure ulcers/injury, prevent infection and the development of additional pressure ulcers/injuries. Basic or routine care interventions could include but are not limited to: .i. Redistribute pressure (such as repositioning, protecting and or offloading heels, etc.); .iv. Provide non-irritating surfaces .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 46939 Based on observation, interview and record review the facility failed to follow professional standards of practice for oxygen administration for three of nine residents receiving oxygen therapy in the facility when: 1. Resident 20 was administered the wrong dose of oxygen. 2. Resident 49 was administered oxygen without a doctor's order. 3. Resident 16 was administered the wrong dose of oxygen. These failures had the potential to negatively affect Resident 20's, Resident 49's, and Resident 16's health. Findings: 1. During a concurrent observation and interview on 5/5/25, at 1:17 p.m., with Registered Nurse (RN) A, in Resident 20's room, Resident 20 was observed wearing a nasal cannula (plastic tubing which supplies oxygen from a machine). RN A stated, she saw Resident 20s oxygen set to between 2.5 and 3 liters (measure of oxygen give to patient per minute). RN A stated, she will lower it, the order is for 2 liters for Resident 20, it should be at 2 liters per the doctor's order. During a review of Resident 20's Order Summary Report dated 5/8/25 indicated, Resident 20 had an order for Oxygen at 2 LPM [liters per minute] via nasal cannula. During a review of Resident 20's Care Plan dated 10/10/24, Care Plan indicated, The resident has oxygen therapy r/t [related to] COPD [Chronic Obstructive Pulmonary Disease: a group of lung diseases that cause ongoing breathing problems].Interventions.Give medications as ordered by physician. 2. During a concurrent interview and record review on 5/5/25, at 1:15p.m, with RN A, Resident 49's Physician Orders was reviewed. The orders indicated, no order for oxygen. RN A stated, there is no order for oxygen, I will call the Doctor and ask for one, we have to have an order for oxygen. During a concurrent observation and interview on 5/5/25, at 1:25 p.m., with RN A, in Resident 49's room. Resident 49 was observed receiving oxygen through a nasal cannula. RN A stated, the oxygen is set to 4 liters. During a review of the facility's Policy & Procedure (P&P) titled, Oxygen Administration, dated, 2014, the P&P indicated, Purpose to administer oxygen to the resident when insufficient oxygen is being carried but the blood to the tissues.Procedure 1. Check physician's order for liter flow and method of administration. 50135 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident 16's Admission Record indicated Resident 16 was admitted to the facility with diagnoses including spinal cord injury (damage to the bundle of nerves that sends and receives signals from the brain), diabetes mellitus (a condition which affects the way the body processes blood sugar), chronic kidney disease, myelofibrosis (chronic blood cancer that causes bone marrow[the soft matter inside the bones] scarring, making it difficult to produce normal blood cells) and anemia (low levels of healthy red blood cells to carry oxygen throughout the body). During an observation on 5/5/25 at 9:23 a.m., Resident 16 was sitting up in bed receiving oxygen through a nasal cannula. Resident 16's oxygen concentrator (machine used to deliver oxygen) was set at 4 LPM. Review of Resident 16's Physician Order Summary Report, dated 8/25/2024, indicated an order of oxygen at 2/LPM. Review of Resident 16's Care Plan Report dated 8/23/2024, indicated, The resident has altered respiratory by difficulty of breathing and has low oxygen level, with an intervention to, Administer oxygen as ordered. During a concurrent observation and interview with LVN B on 5/6/25 at 2:03 p.m., inside Resident 16's room, LVN B confirmed Resident 16's oxygen was administered at 4LPM. LVN B stated Resident 16's oxygen flow rate should have been at 2 LPM. During an interview on 5/6/25 at 2:15 p.m., with the Director of Nursing (DON), the DON stated the oxygen order should always be followed. During a review of the facility's Policy & Procedure (P&P) titled, Oxygen Administration, dated, 2014, the P&P indicated, Purpose to administer oxygen to the resident when insufficient oxygen is being carried but the blood to the tissues.Procedure 1. Check physician's order for liter flow and method of administration.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 46939 Based on interview and record review, the facility failed to ensure 40 out of 69 Certified Nursing Assistants (CNAs) who have worked at the facility for over one year were reviewed annually for a performance review per federal regulation. This failure resulted in the facility being unaware of 40 CNA's performance through the prior year. This failure also had the potential for CNA's performance to be below the standard or practice for patient care. Findings: During a review of CNA I's employee file, undated, employee file indicated, no annual performance review was documented. CNA I's hire date was 9/29/2021 During a review of CNA J's employee file, undated, employee file indicated, no annual performance review was documented. CNA J's hire date was 1/12/2017. During an interview on 5/07/25, at 1:18 p.m., with the Director of Staff Development (DSD), the DSD stated, she took over the position of DSD as interim for the last two weeks. DSD stated, I do not know what the prior DSD's process was, but we looked in her desk and did not find any annual performance reviews for the CNAs. During an interview on 5/7/25, at 1:28 p.m., with the Director of Nursing (DON), the DON stated, we do not see any performance reviews for CNA I, or CNA J. The DON stated, she would get a list of the current CNAs who have not had a performance review. The DON also stated, the CNAs are supposed to have a performance review annually. During a concurrent interview and record review on 5/8/25, at 3:17 p.m., with the DON, the list of CNAs who have not a performance review was reviewed. The list indicated, 40 CNAs out of 69 di not have their annual performance review. The DON stated, this list is all the CNAs who have worked for over one year at least, and they have not had an annual performance review.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48590 Based on interview and record review, the facility failed to ensure accurate accountability of controlled medication (medication with high potential for abuse and addiction) when random controlled medication use audit for three of twelve residents (Residents 93, 3 and 87) did not reconcile when: 1. The medication was documented on the Medication Administration Record (MAR, used to document medications taken by each individual) to indicate they were administered to Resident 93 but was not signed out of the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications). 2. The medication was signed out of the CDR but not documented on the MAR for Resident 87 and Resident 3. The failure resulted in inaccurate accountability and had the potential for misuse or diversion of controlled medications. Findings: 1. The Controlled Drug Record (CDR) for twelve residents receiving controlled medications were requested for review during the survey. A review of Resident 93's clinical record indicated she had a Physician order for Hydrocodone-Acetaminophen (Norco, a controlled medication for pain) 10-325 milligrams (mg, unit of measurement) 1 tablet every 4 hours for pain, dated 4/24/25. During a concurrent interview and record review on 5/5/25 at 7:48 a.m., with Registered Nurse (RN) H, RN H stated she gave the medication at 12:15 a.m. but forgot to sign the CDR. During an interview on 5/6/25 at 2:16 p.m., with the Director of Nursing (DON), the DON stated that the narcotic sheet, which is the CDR, should be signed as soon as the medication was given and signed in the MAR. 2. A review of Resident 3's clinical record indicated she had a Physician order for Norco 5-325 mg 1 tablet every 6 hours as needed for severe pain, dated 4/17/25. During a concurrent interview and record review on 5/6/25 at 2:32 p.m., with the DON, a review of Resident 3's CDR for Norco and the 4/2025 MAR reflected the nursing staff removed the medication from the locked controlled medication compartment in the medication cart and signed out of the CDR on 4/18/25 at 9:35 a.m. , but did not document the respective administration on the MAR. The DON acknowledged that the controlled medication was not accounted for in the MAR. A review of Resident 87's clinical record indicated she had a Physician order for Oxycodone Hydrochloride (a controlled medication for pain) 5 mg per 5 milliliter (ml, unit of measurement) give 2.5 ml every 6 hours as needed for severe pain., dated 4/5/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/6/25 at 2:39 p.m., with the DON, a review of Resident 87's CDR for Oxycodone and the 4/2025 MAR reflected the nursing staff removed the medication from the locked controlled medication compartment in the medication cart and signed out of the CDR on 4/15/25 at 10:15 p.m., but did not document the respective administration on the MAR. The DON acknowledged that the controlled medication was not accounted for in the MAR. A review of the facility's Medication Administration policy and procedure (P&P), dated 4/9/25, indicated Policy Explanation and Compliance Guidelines .21. If medication is a controlled substance, sign narcotic book. A review of the facility's General Dose Preparation and Medication Administration P&P, dated 11/15/24, indicated 5.5 Document the administration of controlled substances in accordance with applicable law .6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information .on appropriate forms .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. 44577 Based on interview and record review, the facility failed to ensure one of 35 sampled residents (Resident 34) was free from inappropriate and unnecessary medication use when the medication Midodrine HCl (to treat low blood pressure) was given outside of the ordered parameters. This failure had the potential for causing harm to Resident 34's health and well-being. Findings: During review of Resident 34's medication administration record (provides a comprehensive, organized record of each medication administered to a patient) (MAR), dated May 2025, the MAR indicated Resident 34 received Midodrine HCl 5 milligrams (a unit of measure) (Mg) on 5/8/25 when the blood pressure (refers to the force of circulating blood against the walls of blood vessels. Blood pressure is measured in two values: systolic [highest pressure during a heartbeat] and diastolic [lowest pressure between heartbeats]) was 126/68. During review of Resident 34's orders dated 3/4/25, the order indicated Midodrine HCl oral tablet 5 MG, one tablet by mouth three times a day for hypotension, hold for SBP (systolic blood pressure) greater than 120 mmHg. During review of Resident 34's MAR dated March 2025 and April 2025, the MAR for March 2025 indicated Midodrine HCl was given five times when SBP was above 120 (3/6/25, 3/8/25, 3/9/25, 3/15/25 and 3/25/25). The MAR for April 2025 indicated Midodrine HCl was given eight times when SBP was above 120 (4/1/25, 4/5/25, 4/15/25 two times, 4/17/25, 4/19/25, and 4/27/25 two times). During a concurrent interview and record review on 5/8/25 at 2:00 p.m. with Licensed Vocational Nurse (LVN) K, Resident 34's orders and MAR for March, April and May 2025 were reviewed. LVN K stated the order indicated to hold for SBP greater than 120 mmHg. LVN K confirmed Resident 34 should not have received medication when the SBP was greater than 120 mmHG on the 14 incidents reviewed. Review of the facility's policy and procedure titled, Medication Administration, dated 4/9/25, indicated Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician 's prescribed parameters.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48590 Based on observation, interview and record review, the facility failed to ensure expired medication was removed in one of three medication carts (med cart AA)) when a bottle of Mirtazapine (used to treat depression [a mood disorder characterized by persistent sadness and a loss of interest in activities]) 15 milligrams (mg, unit of measurement) with expiration date of [DATE] was identified. The failure had the potential for residents to receive medications with reduced potency. Findings: During an inspection of the med cart AA and interview with Licensed Vocational Nurse (LVN) B on [DATE] at 12:08 p.m., a bottle of Mirtazapine was found in the medication cart that expired on [DATE]. LVN B confirmed that the medication has expired and should have been removed. During an interview on [DATE] at 2:20 p.m., with the Director of Nursing (DON), the DON stated the expired medication should have been removed from the medication cart. During a review of the facility's Disposal/Destruction of Expired or Discontinued Medication policy and procedure (P&P), dated [DATE], indicated Facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. During a review of the facility's Labeling of Medications and Biologicals P&P, dated [DATE], indicated All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. During a review of the facility's Medication Storage P&P, dated [DATE], indicated Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46939 Based on interview and record review, the facility failed to identify the lack of annual performance reviews for Certified Nursing Assistants (CNAs) in their Quality Assurance Performance Improvement Plan (QAPI- a plan developed by the facility with the goal of improving conditions in the facility) when monitoring of employee files was not documented as reviewed for regulatory compliance, per the QAPI monitoring plan. As a result, the facility did not identify 40 of 69 CNAs employeed by the facility did not have a documented annual performance review. (see F730). Findings: During a review of the facility's QAPI Plan, updated 2017, QAPI plan indicated, Quality Surveillance Data. Education/In-Service Tracking, Responsible for Review/reporting to Committee Director of Staff Development, Action Plan(s) required for: Federal/State required in-services not completed per regulations, personnel files audits that result in negative findings. QAPI Plan indicated, Random personnel file reviews should occur quarterly to determine compliance with training and documentation requirements as well as mandatory hiring criteria and license verification. Results of random audits should be reviewed by the Executive Director with training summary and audit findings reported to the QA&A [QAPI] Committee for review and process improvement. During an interview on 5/9/25, at 9:23 a.m., with the Administrator in Training (AIT), the AIT stated, he does not have documentation of the DSD having performed random audits of personnel files. AIT stated the facility was not aware CNA annual performance reviews were not being completed.

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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** 44577 Based on observation, interview and record review, the facility failed to ensure staff were implementing infection prevention practices when: 1. One of four Certified Nursing Assistances (CNA) failed to perform hand hygiene between residents during dining; 2. Resident 309's intravenous (IV, to deliver a medication into a vein) tubing tip left uncapped when not in use. During an observation on 05/06/25 at 12:53 p.m., Certified Nursing Assistant (CNA) F, was in the dining room sitting between Resident 5 and Resident 44 feeding them both lunch without cleaning her hands between Residents. During an interview on 05/06/25 at 3:07 p.m., CNA F stated, She washes hands prior to feeding the residents but does not clean hands between residents when feeding two residents at the same time. Review of the facility's policy and procedure titled Hand Hygiene, dated 5/29/24 indicated, Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table .Between resident contacts. Review of the facility's policy and procedure titled Infection Prevention and Control Program, dated 2/5/25 indicated, All staff are responsible for following all policies and procedures related to the program. 50135 Review of Resident 309 's clinical record indicated Resident 309 was admitted on [DATE] with diagnoses including post digestive system (a group of organs in the body that break down food into its simplest forms) surgery care, severe protein-calorie malnutrition, and status post gastrostomy (GT tube, a surgical opening into the stomach for the administration of nutrition and medications). Review of the Order Summary Report for Resident 309 indicated a physician order dated 5/4/25 for 0.45% sodium chloride (low salt fluid) intravenous sodium solution. Use intravenously every shift for IV hydration (provides fluid to the body when food by mouth is insufficient or not possible. During a concurrent observation and interview on 5/7/25 at 9:55 a.m. with Licensed Vocational Nurse D (LVN D) inside Resident 309's room, LVN D confirmed the tip of the IV tubing was left uncapped and exposed to air while not in use. LVN D stated, It should not be like that. LVN D also stated, It should have a small cap on the end to prevent infection. Review of the facility's policy and procedure titled, Infection Prevention and Control Program, dated 2/5/25 indicated, All staff are responsible for following all policies and procedures related to the program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055645	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Skilled Nursing & Subacute Center	410 North Winchester Boulevard Santa Clara, CA 95050

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 46939 Based on observations and interviews, the facility failed to ensure all multiple-resident bedrooms provided at least 80 square feet per resident for 9 of 60 rooms observed. This failure had the potential for Residents in rooms #301, #302, #303, #304, #305, #309, #311, #312, and #314 to have less space available for daily care and assistance. Findings: During observations from 5/5/25 to 5/9/2025 in rooms #301, #302, #303, #304, #305, #309, #311, #312, and #314., each room was a two-resident room and measured 13 feet by 11 feet, resulting in a total square footage of 143 square feet, or 71.5 square feet per resident. During the observation, residents reported they had plenty of space and did not have concerns with the size of their rooms. During an interview on 5/5/25 at 8 am with the Administrator, the Administrator, stated social services asks the residents or their families each quarter if there were any problems with the room size and none had been reported. The Administrator indicated the smaller room size did not inhibit resident care, and the facility has a room waiver.