STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055646	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palo Alto Sub-Acute and Rehabilitation Center	911 Bryant Street Palo Alto, CA 94301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat one of 14 residents (8) with respect and dignity when certified nursing assistant A (CNA A) was standing and feeding Resident 8. This failure had the potential to cause feeling of low self-esteem for the resident. Findings: Review of Resident 8's admission Record indicated she was admitted to the facility on [DATE]. During an observation on 5/28/25, at 12:37 p.m., CNA A was standing and feeding lunch to Resident 8 in her room. During a concurrent interview with CNA A, she stated that she did not feel comfortable if she sat down and fed Resident 8, because she had to reach to Resident 8 to feed her. CNA A acknowledged that she could adjust the bed level and reposition Resident 8, so that she could reach to Resident 8 comfortably. CNA A stated she should sit down while feeding Resident 8. Review of the facility's policy, Promoting/Maintaining Resident Dignity During Mealtimes, dated 10/21/24, indicated . 5. All staff will be seated, if possible, while feeding a resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect resident's rights to confidentiality for one of 14 residents (112) when the infection preventionist (IP) left her laptop screen open with Resident 112's face sheet (a document summarizing key patient information, including name, address, date of birth , emergency contact, medical history, medications, allergies, and insurance details) open and unattended on top of the stand in the hallway. This failure had the potential to compromise the resident's privacy and confidentiality. Findings: Review of Resident 112's admission Record indicated he was admitted to the facility on [DATE]. During an observation on 5/27/25, at 10:55 a.m., the IP was in the hallway. Her laptop was on the stand and in front of her. The laptop was open with Resident 112's face sheet displayed on the screen. The IP left her laptop there and walked to the lobby to talk with the maintenance director. Then, the IP walked farther, across the lobby, to the other hallway to talk with other staff. During an interview with the IP on 5/27/25, at 10:57 a.m., she confirmed that she left her laptop open with Resident 112's face sheet open and unattended in the hallway. The IP stated she should close her laptop before walking away to talk with other staff. Review of the facility's policy, Health Insurance Portability and Accountability Act (HIPAA, a federal law that sets a national standard to protect medical records and other personal health information) Security Measures, dated 5/12/25, indicated . 8. Physical safeguards will be implemented that limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed.

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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** Based on interview and record review, the facility failed to ensure two of 14 sampled residents (Resident 39 and Resident 22) were free from unnecessary psychotropic medication (medications that affect brain activities associated with mental processes and behaviors) use when: 1. Resident 39 was administered Belsomra (Suvorexant, a sedative hypnotic medication used to treat insomnia) without informed consent (a process where the resident or their representative is educated about the risks, benefits, and alternatives to a medication before agreeing to its use), monitoring for sleep or side-effects, and a care plan addressing the medication's use. 2. Resident 22 did not have an updated informed consent when antipsychotic medication, Perphenazine (used to treat the symptoms of schizophrenia, a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) dose was increased. These failures put residents at risk for adverse effects of psychotropic medications. Findings: 1. A review of Resident 39's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included: depression (a mental health condition that causes persistent sadness and loss of interest), and schizoaffective disorder (a chronic mental health condition that includes symptoms of hallucinations or delusions). A review of Resident 39's Order Summary Report indicated that on 5/19/25, the physician prescribed Belsomra 10 milligrams (mg, unit of measurement), to be given as one tablet by mouth at bedtime for insomnia (difficulty sleeping). A review of Resident 39's clinical records showed no documentation of informed consent before initiating Belsomra, sleep monitoring or monitoring for side-effects, or a care plan that included the use of Belsomra or interventions. During a concurrent interview and record review with the Director of Nursing (DON) on 5/30/25 at 10:30 a.m., the DON confirmed that there was no documented informed consent obtained before Belsomra was administered to Resident 39. There was no monitoring for sleep or side-effects recorded after the medication was started. The DON further stated that Resident 39's care plan addressed the problem of insomnia, but did not include specific interventions related to the use of Belsomra or monitoring its side-effects. (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 facility's policy titled Use of Psychotropic Medications, revised date 2/5/25, indicated: .9) Prior to initiating or increasing psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication .the facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline .14) The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluate on an ongoing basis, such as .d) In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care. 15) The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record . 2. A review of Resident 22's clinical records indicated an initial admission date of 9/17/24 and diagnoses included, bipolar disorder, unspecified (a mental health condition where a person experiences extreme shifts in mood, energy, and activity levels, moving between periods of intense happiness and energy [mania] and periods of sadness and low energy [depression]) and, schizophrenia, unspecified (a chronic brain disorder that affects how a person thinks, feels, and behaves, leading to a disconnection from reality). A review of Resident 22's Physician order dated 5/9/25 indicated, Perphenazine Oral tablet 8 MG Give 2 tablet by mouth two times a day for Schizophrenia During a concurrent interview and record review of Resident 22's clinical records with the DON on 5/30/25 at 12:06 p.m., the DON verified Resident 22 did not have an updated informed consent for the current Perphenazine dose. The DON verified, the informed consent indicated Perphenazine 5 mg to be given 2 tablets twice daily. A review of the facility's policy and procedure (P&P) entitled, Use of Psychotropic Medication (s) revised on 2/5/25, the P&P indicated, .9. Prior to initiating a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase .

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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. Based on interview and medical record review, the facility failed to develop and implement a comprehensive person-centered plan of care for two out of 14 sampled residents (Residents 48 and 22) when: 1. Resident 48 did not have a comprehensive care plan specific to the medication Aripiprazole (an antipsychotic medication used to treat several mental health conditions) and interventions indicated in the care plan were not followed. 2. Resident 22 did not have a comprehensive care plan specific to the medication Perphenazine (used to treat the symptoms of schizophrenia, a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). These failures put residents at risk for inadequate monitoring of possible adverse effects specific to their antipsychotic medications. Findings: 1. A review of Resident 48's clinical record indicated an admission date of 3/25/25 and diagnoses included anxiety disorder, unspecified (a mental health condition where excessive worry, fear, and apprehension interfere with daily life), depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in previously enjoyable activities), and unspecified mood [affective] disorder (a mental health condition characterized by persistent and significant changes in a person's mood, thoughts, and behaviors). A review of Resident 48's Physician Order indicated, Abilify Oral Tablet 5 MG [milligram, a unit of measurement] (Aripiprazole) Give 1 tablet by mouth at bedtime for UNSPECIFIED MOOD [AFFECTIVE] DISORDER M/B mood swing, hallu [hallucinations] GDR [gradual dose reduction, tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose] ordered on 5/13/25. A review of Resident 48's nursing care plan interventions initiated on 3/26/25 indicated, Complete AIMS [Abnormal Involuntary Movement Scale, used to assess the presence and severity of unwanted, involuntary movements in patients, particularly in areas like the face, mouth, limbs, and trunk] assessment every 6 months and with each increase in dose of antipsychotics During a concurrent interview and record review of Resident 48's clinical records with the Director of Nursing (DON) on 5/30/25 at 11:50 a.m., the DON verified there was no care plan specific for the medication Aripiprazole. The DON also verified Resident 48 did not have a baseline AIMS. The DON also verified Aripiprazole had a black box warning (the strongest warning the U.S. Food and Drug Administration (FDA) can place on a drug label. It indicates a serious, life-threatening side effect or a high risk of harm associated with the medication). During a concurrent interview and record review on 5/30/25 at 3:41 p.m. with the pharmacist consultant (PC), the PC stated a baseline AIMS would be appropriate. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure (P&P) entitled, Use of Psychotropic Medication (s) revised on 2/5/25, the P&P indicated, .13. AIMS monitors Parkinsonian Symptoms [problems with movement, including shaking (tremor), stiffness (rigidity), and slow movement (bradykinesia), as well as balance issues] such as Extrapyramidal symptoms [side effects caused by certain medications, particularly antipsychotics, that affect the motor system] 14. The effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis such as: d. In accordance with the nurse assessments and medication monitoring parameters consistent with the clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care . A review of facility's policy and procedure (P&P) entitled Resident Rights revised on 3/4/25, the P&P indicated, .2. Planning and implementing care .a .iv. The right to receive the services and/or times included in the plan of care. 2. A review of Resident 22's clinical records indicated an initial admission date of 9/17/24 and diagnoses included, bipolar disorder, unspecified (a mental health condition where a person experiences extreme shifts in mood, energy, and activity levels, moving between periods of intense happiness and energy [mania] and periods of sadness and low energy [depression]) and, schizophrenia, unspecified (a chronic brain disorder that affects how a person thinks, feels, and behaves, leading to a disconnection from reality). A review of Resident 22's Physician order dated 5/9/25 indicated, Perphenazine Oral tablet 8 MG Give 2 tablets by mouth two times a day for Schizophrenia During a concurrent interview and record review of Resident 22's clinical records with the DON on 5/30/25 at 12:06 p.m., the DON verified, there was no nursing care plan specific for Perphenazine. The DON stated specific medications were not included in the nursing care plan. The DON also verified Resident 22 had nursing care plans specific to other psychotropic medications (drugs that affect the brain and are used to treat mental health conditions like depression, anxiety, and schizophrenia) such as Bupropion (medication primarily used as an antidepressant) and Sertraline (medication primarily used as an antidepressant). A review of facility's policy and procedure (P&P) entitled, Use of Psychotropic Medication (s) revised on 2/5/25, the P&P indicated, . 14. The effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis such as: d. In accordance with the nurse assessments and medication monitoring parameters consistent with the clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care . A review of facility's policy and procedure (P&P) entitled, Comprehensive Care Plans revised 2/5/25, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality .

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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** Based on interview and record review, the facility failed to ensure the residents received the necessary care and services for one of 14 residents (112) when Resident 112 was admitted with a pacemaker (electric activity-generating device used to treat patients with slow heart rates) but there was no information on the pacemaker found in his clinical record. This failure had the potential to negatively affect the resident's health, well-being, and safety. Findings: Review of Resident 112's admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 112's physician order, dated 5/22/25, indicated Resident 112 had a pacemaker. However, there were no information on the pacemaker such as the cardiologist information, the implant date, the device model, device serial number, lead (a wire that connects a pacemaker to the heart) model, lead serial number, battery longevity, device lower rate and maximum rate, and device checkup period found in Resident 112's clinical record. During an interview with the director of nursing (DON) on 5/30/25, at 2:30 p.m., she reviewed Resident 112's clinical record and was unable to find the information on his pacemaker. The DON stated she would request Resident 112's pacemaker information and keep them in his clinical record. Review of the facility's 2024 policy, Use of Pacemaker, indicated . 4. All documentation about the pacemaker will be placed in the residents' chart and part of their permanent record.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents receive the pain management according to their pain levels for one of two residents (53) when the licensed nurses administered Norco (used to relieve severe pain) 5-325 milligrams (mg, a metric unit of mass) to Resident 53 when she did not have severe pain. This failure had the potential for Resident 53 to experience unnecessary adverse effects from the pain medication. Findings: Review of Resident 53's admission Record indicated she was admitted to the facility on [DATE] with aftercare following joint replacement surgery diagnosis. Review of Resident 53's physician order, dated 5/1/25, indicated she had an order for Norco 5-325 mg one tablet every 4 hours as needed for severe pain level 7-10. Review of Resident 53's 5/2025 Medication Administration Record (MAR) indicated the licensed nurses administered Norco 5-325 mg one tablet to Resident 53 when her pain level was less than 7 on 5/4/25 at 5:09 a.m., 5/6/25 at 9:22 a.m., 5/9/25 at 05:02 a.m., 5/9/25 at 9:45 a.m., 5/10/25 at 9:56 a.m., 5/12/25 at 10:35 a.m., 5/13/25 at 9:06 a.m., 5/13/25 at 2:40 p.m., 5/14/25 at 1:07 a.m., 5/14/25 at 5:42 a.m., 5/15/25 at 8:51 a.m., 5/17/25 at 9:30 a.m., 5/17/25 at 6:25 p.m., 5/18/25 at 4:36 a.m., 5/18/25 at 11:12 a.m., 5/18/25 at 8:19 p.m., 5/20/25 at 5:10 a.m., 5/24/25 at 7:59 p.m., 5/25/25 at 2:33 p.m., 5/26/25 at 4:37 a.m., 5/26/25 at 8:34 a.m., 5/26/25 at 1:57 p.m., and on 5/27/25 at 4:35 a.m. During an interview with the director of nursing (DON) on 5/30/25, at 2:43 p.m., she reviewed Resident 53's 5/2025 MAR and confirmed that the licensed nurses administered Norco 5-325 mg one tablet to Resident 53 when her pain level was less than 7 on 5/4/25 at 5:09 a.m., 5/6/25 at 9:22 a.m., 5/9/25 at 05:02 a.m., 5/9/25 at 9:45 a.m., 5/10/25 at 9:56 a.m., 5/12/25 at 10:35 a.m., 5/13/25 at 9:06 a.m., 5/13/25 at 2:40 p.m., 5/14/25 at 1:07 a.m., 5/14/25 at 5:42 a.m., 5/15/25 at 8:51 a.m., 5/17/25 at 9:30 a.m., 5/17/25 at 6:25 p.m., 5/18/25 at 4:36 a.m., 5/18/25 at 11:12 a.m., 5/18/25 at 8:19 p.m., 5/20/25 at 5:10 a.m., 5/24/25 at 7:59 p.m., 5/25/25 at 2:33 p.m., 5/26/25 at 4:37 a.m., 5/26/25 at 8:34 a.m., 5/26/25 at 1:57 p.m., and on 5/27/25 at 4:35 a.m. The DON stated the licensed nurses should administer pain medication to the residents according to the pain level as ordered by the physician. Review of the facility's job description, Registered Nurse, dated 11/13/17, indicated . Medication and Treatment Administration Functions: . Complies with professional standards, policies and procedures, and legal documentation principles for administering medications, treatments, enteral, and intravenous therapies.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the proper use of side rails or bed rails (adjustable rigid bars attached to the side of a bed) for two of 20 residents who used side rails, (Residents 19 and 28), when their side rail assessments (determine the appropriateness and safety of using side rails on a bed for an individual) were not updated in a timely manner. This failure had the potential to place the residents at risk for entrapment (danger for the resident, being caught, trapped or entangled in the gap, space or opening) that may lead to injury or death. Findings: 1. During an observation of Resident 19, on 5/27/25 at 10:38 a.m., Resident 19 was in bed, alert, calm, comfortable and verbally responsive. Resident 19's one fourth (quarter) side rail was up. Review of Resident 19's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident), indicated, Resident 19 was readmitted to the facility on [DATE] with the primary diagnosis of unspecified arthropathic psoriasis (long-term inflammatory arthritis that may occur in some people affected by the autoimmune disease psoriasis). Review of Resident 19's physician orders indicated, Resident 19 had an order on 2/21/24 for side rails for prompt bed mobility. Review of Resident 19's side rail assessment indicated, it was last updated on 2/12/25. During the concurrent review of the side rail assessment of Resident 19 and interview with the Director of Nursing (DON), on 5/30/25 at 1:05 p.m., the DON acknowledged that the side rail assessment of Resident 19 was not updated regularly or quarterly. The DON further acknowledged that Resident 19's side rail assessment was last updated on 2/12/25 and it should have been updated already at this time. 2. During an observation of Resident 38, on 5/27/25 at 10:30 a.m., Resident 38 was laying in his bed, alert, calm, comfortable and verbally responsive. Resident 38 had his bilateral (both sides), half side rails up. Review of Resident 38's admission record indicated, Resident 38 was readmitted to the facility on [DATE] with the primary diagnosis of unspecified displaced fracture (occurs when bone is broken and the broken pieces are not aligned) of third cervical vertebra (part of the seven vertebrae that makes up the neck), subsequent encounter for fracture with routine healing (healing of the fracture is progressing as expected). Review of Resident 38's physician orders indicated, Resident 38 had an order on 2/12/25 for side rails for bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 38's side rail assessment indicated, it was last updated on 1/7/25. During the concurrent review of the side rail assessment of Resident 38 and interview with the DON, on 5/30/25 at 1 p.m., the DON verified that the side rail assessment of Resident 38 was not updated regularly or quarterly. The DON further verified that Resident 38's side rail assessment was last updated on 1/7/25 and it should have been updated already. Review of the facility's policy and procedure titled, Proper Use of Bed Rails, implemented on October 2022 indicated, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails .The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices .Responsibilities of ongoing monitoring and supervision are specified as follows: A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon significant change in status, or change in the type of bed/mattress/rail .

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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** Based on interview and record review, the facility failed to ensure the effective use of medications for one of 14 residents (112) when Resident 112 received Ferosul (iron, used for prevention/treatment of iron deficiency) and Calcium Citrate (a medication used to prevent or treat low blood calcium levels) at the same time. This failure had the potential for the residents to not receive the amount of prescribed iron supplements. Findings: Review of Resident 112's admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 112's clinical record indicated, he had physician orders for Ferosul 325 milligrams (mg, a metric unit of mass) every 48 hours for anemia (a problem of not having enough healthy red blood cells to carry oxygen to the body's tissues) at 9 a.m., started on 5/23/25, and for Calcium Citrate 250 mg every day at 9 a.m. and 5 p.m., started on 5/22/25. Thus, since 5/23/25, Ferosul and Calcium Citrate were given at the same time at 9 a.m. every 48 hours. During an interview with the pharmacist consultant (PC) on 5/30/25, at 1:56 p.m., she stated Ferosul and Calcium Citrate should be administered at least two hours apart due to drug-to-drug interaction that decreases the absorption of iron. According to Lexicomp (www.[NAME].com), a nationally recognized drug information resource, the concurrent use of calcium and ferrous sulfate led to a drug-drug interaction (DDI) of Risk Rating D, which was a significant interaction and required therapy modification. The effect of DDI was that the calcium may decrease the absorption of oral preparations of iron salts. It indicated the iron absorption decreased an average of 60% when given as ferrous sulfate and co-administered with calcium. Lexicomp also indicated to separate the administrations of these medications so it may minimize the potential for significant interaction. Review of the facility's 2023 policy, Adverse Drug Interactions, indicated The pharmacy will perform an initial assessment of the complete medication profile for potential adverse drug interactions and other contraindications or precautions on all new patient orders at the time of admission. The pharmacy will perform continual and ongoing assessment of the complete medication profile for adverse interactions and other contraindications for each new order received thereafter.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pharmacist consultant's recommendation was acted upon for one of 14 residents (115) when Resident 115's administration record on alendronate (used to prevent and treat osteoporosis [thinning of the bone]) did not include the information the pharmacist consultant asked to be included. This failure had the potential for Residents 115 to receive ineffective medication and adverse effects that could negatively impact her health and well-being. Findings: Review of Resident 115's admission Record indicated she was admitted to the facility on [DATE] with osteoporosis diagnosis. Review of Resident 115's Consultation Report, dated 5/20/25, indicated the pharmacist consultant recommended to include in Resident 115's administration record on alendronate the following information: Administer intact tablet at least 30 minutes before the first food, beverage, or medication of the day with 6 to 8 ounces of plain water. Individuals should not lie down for at least 30 minutes and until after the first food of the day. However, review of Resident 115's administration record on alendronate did not indicate that the pharmacist consultant's recommendation was included. During an interview with the director of nursing (DON) on 5/30/25, at 2:47 p.m., she reviewed Resident 115's clinical record and confirmed that the pharmacist consultant's recommendation for her alendronate was not acted upon. Review of the facility's policy, Medication Regimen Review (MRR), dated 4/9/25, indicated . Policy Explanation and Compliance Guidelines: . 7. Timelines and responsibilities for MRR: . f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 6 residents (112) were free from unnecessary medications when Resident 112 received dabigatran etexilate mesylate (a blood thinner to prevent blood clots) but was not monitored for the side effects and not care-planned on the use of the medication. This failure had the potential for Resident 112 to experience unrecognized adverse effects. Findings: Review of Resident 112's admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 112's physician order, dated 5/23/25, indicated he had an order for dabigatran etexilate mesylate 110 milligrams (mg, a metric unit of mass) two times a day. However, review of Resident 112's clinical record did not indicate that Resident 112 was monitored for the side effects and was care-planned on the use of the medication. During an interview with the director of nursing (DON) on 5/30/25, at 2:26 p.m., she reviewed Resident 112's clinical record and confirmed that Resident 112 was not monitored for the side effects and was not care-planned on the use of the medication. Review of the facility's policy, Anticoagulant Therapy, dated 8/2014, indicated . Procedure: . 5. Monitor for signs and symptoms of adverse drug effects, including, but not limited to, abnormal or prolonged bleeding, excessive bruising, blood in stool or urine, coffee ground emesis, bleeding from eyes, nose, or gums, etc. 8. Include anticoagulant use and monitoring in care plan.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a 12% medication error rate when three medication errors out of 25 opportunities were observed during a medication pass for three out of five sampled residents (Residents 44, Resident 2, and Resident 8) when: 1. Resident 44 did not receive Calcium Carbonate with Vitamin D tablet (used to treat conditions caused by low calcium levels such as bone loss) as ordered by the physician. 2. Resident 2 received Diroximel Fumarate capsule (medication used for the treatment of relapsing forms of multiple sclerosis, a disease that causes breakdown of the protective covering of nerves) without food. 3. Resident 8 did not receive Fluticasone-Salmeterol inhalation (used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma) as ordered by the physician. These failures resulted in medications not given in accordance with the manufacturer's instructions and/or physician's order and had the potential for residents not receiving the full therapeutic effects of medications. Findings: 1. During a medication pass observation on 5/27/25 at 11:27 a.m. with Registered Nurse (RN) E, RN E was preparing medications for Resident 44. RN E stated Resident 44 is due to have Calcium Carbonate with Vitamin D but was not available. RN E also stated pharmacy and physician will be notified. A review of Resident 44's Physician Order dated 5/12/25 indicated, Calcium 600 + D oral tablet 500-5 mg-mcg [milligram-microgram, units of measurement] (calcium carbonate-vitamin D) give 1 tablet by mouth three times a day for supplement. During a concurrent interview and record review of Resident 44's Medication Administration Record (MAR) for May 2025 with the Director of Nursing (DON) on 05/29/25 at 3:44 p.m., the DON verified Calcium Carbonate with Vitamin D was not given at 9 a.m. and 1 p.m. on 5/27/25. A review of facility's policy and procedure (P&P) entitled, Medication Administration revised 4/9/25, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . 2. During a medication pass observation on 5/28/25 at 4:03 p.m. with Licensed Vocational Nurse (LVN) F, LVN F was preparing medications for Resident 2 which included, Gabapentin (a medication primarily used as an anticonvulsant) 300 mg (milligram, unit of measurement) tablet, Sucralfate (medication that treats stomach ulcers) 1 gram tablet, and 2 capsules of Diroximel Fumarate 231 mg. Resident 2 took the medications with a glass of water. There was no food tray observed on Resident 2's table. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's physician order indicated, Vumerity Capsule delayed release 231 mg [milligram, unit of measurement] (diroximel fumarate) give 2 capsules by mouth two times a day for multiple sclerosis, administer at least 20 minutes after food is taken. During a concurrent interview and record review of Resident 2's clinical record with the DON, the DON verified diroximel fumarate was scheduled to be given before dinner. The DON stated the nurse should have asked if Resident 2 had taken food. The DON also stated the medication must be scheduled after meals or a snack should be offered prior to administration. A review of facility's policy and procedure (P&P) entitled, Medication Administration revised 4/9/25, the P&P indicated, .17. Administer medication as ordered in accordance with manufacturer specifications. a. Provide appropriate amount of food and fluid . 3. During a medication pass observation on 5/28/25 at 4:09 p.m. with Licensed Vocational Nurse (LVN) F, LVN F prepared medication for Resident 8 which included, Calcium with Vitamin D3 tablet. LVN F stated Resident 8 was due for a breathing treatment that was not available. Resident 8 took Calcium with Vitamin D3 tablet with a glass of water. A review of Resident 8's physician order indicated, Wixela Inhub Aerosol Powder Breath Activated 250-50 mcg/act [microgram per actuation, a unit of measurement] (fluticasone-salmeterol) 1 puff inhale orally two times a day for asthma rinse mouth after each dose. During a concurrent interview and record review of Resident 8's clinical records with the DON on 5/29/25 at 3:44 p.m., the DON verified fluticasone-salmeterol inhalation was not administered for Resident 8 on 5/28/25 due at 5 p.m. A review of facility's policy and procedure (P&P) entitled, Medication Administration revised 4/9/25, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were stored appropriately and in good sanitary condition when: 1. Medication refrigerator had ice build up in the freezer and had a streak of yellowish-brown substance on the shelf bracket. 2. Five expired over-the-counter medications, and an opened bottle of medication for a discharged resident were found in the Central Supply Room. These failures put residents at risk for contaminated medications and had the potential for residents to receive outdated and/or ineffective medications which could lead to residents not receiving the full benefit of the medications and negative health outcomes. Findings: 1. During an inspection of the medication room on 5/27/25 at 10:21 a.m. with the Director of Nursing (DON), a mini refrigerator was inside. The DON confirmed there was an ice buildup in the freezer. The DON verified the ice buildup blocked the freezer door and cannot be closed and was hard to open. The DON also verified there was a streak of yellowish-brown substance found inside refrigerator on the right shelf bracket. The DON stated, We could clean it better. A review of facility's policy and procedure (P&P) entitled Medication Storage revised 4/9/25, the P&P indicated, It is the policy of this facility to ensure all medications housed on our premises will be stored in pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security . 2. During an inspection of the Central Supply Room (CSR) on 5/27/25 at 10:30 a.m. with the DON, the DON stated over-the-counter medications and other supplies were stored in the CSR. The DON confirmed the following were stored in the CSR: a. A bottle of Vitamin D3 125 mcg (microgram, unit of measurement) capsules with expiration date 1/2025. b. 2 bottles of Acetaminophen 325 mg (milligram, unit of measurement) tablets with expiration date 12/2024. c. A bottle of Acetaminophen 325 mg (milligram, unit of measurement) tablets with expiration date 8/2024 d. A tube of Zinc Oxide Formula non greasy barrier cream with expiration date 3/2025 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. An opened bottle of Pancrelipase capsules (used to improve digestion of food for people who have a condition in which the pancreas does not have enough enzymes needed to break down food so it can be digested) labeled with a discharged resident's name. The DON stated she did not know why the expired medications were there. The DON also confirmed the opened bottle of Pancrelipase belonged to a discharged resident and should not have been there. A review of facility's policy and procedure (P&P) entitled Medication Storage revised 4/9/25, the P&P indicated, .8. 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. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure palatability and temperature of the foods served were maintained when: 1. The pureed (a smooth, thick liquid or paste made by crushing or grinding solid foods using a blender or food processor) fish and pureed bread tasted bland (lacking taste or flavor); and 2. The temperature of the hot foods served were below the desired level. These failures could lead to decreased nutrient intake for the 55 facility residents receiving food from the kitchen. Findings: 1. During the test tray observation and tasting with the dietary manager (DM), on 5/28/25 at 12:45 p.m. to 12:52 p.m., two test plates in the trays were brought and tasted. One of the test plates contained regular (no modification or restriction) fish, regular vegetables and regular orzo (type of short-cut pasta that is shaped like a large grain of rice). The second test plate contained pureed fish, pureed bread, pureed vegetables and pureed orzo (pasta). Tasted the pureed foods after and the pureed fish and pureed bread had no taste or tasted bland. During an interview with the DM after he tasted the test plate with pureed foods, on 5/28/25 at 12:53 p.m., the DM acknowledged that the pureed fish and pureed bread, tasted bland. The DM further acknowledged that he would follow up on this concern and on improving the taste of these pureed foods. During an interview with the registered dietitian (RD), on 5/29/25 at 2:35 p.m., the RD verified that the foods to be served to the residents should be palatable and not bland in taste. The RD further verified that he would check on this concern. Review of the facility's policy titled, Food and Dining Services Policies and Procedures: Resident Food Preferences, effective 11/2016 indicated, Satisfy resident's tastes and appetites by determining their food preferences at meals . Review of the facility's policy titled, Food and Dining Services Policies and Procedures: Recipes, effective 2/2009 indicated, Ensure consistent food and dining quality . Review of the facility's policy and procedure titled, Food and Dining Services Policies and Procedures: Resident Food Acceptability, effective 2/2009 indicated, Resident's acceptance of the menu and food is monitored routinely. All food and dining services staff and nursing staff are responsible for monitoring resident meal satisfaction . 2. During the test tray observation and tasting with the DM, on 5/28/25 at 12:45 p.m., the DM checked the temperatures of the foods in the two test plates in the trays that were brought, before they were tasted. The temperatures of the following hot foods were below 135 degrees Fahrenheit (F, temperature scale), which was the required temperature of the hot foods to be served in the facility: a. regular fish - 134 degrees F; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. regular vegetable - 125 degrees F; c. puréed fish - 122 degrees F; d. puréed orzo - 117 degrees F and e. puréed bread - 114 degrees F. During an interview with the DM on 5/29/25 at 4:35 p.m., the DM verified that the hot foods to be served to the residents should be 135 degrees F or above and temperatures of the regular fish, regular vegetables, pureed fish, pureed orzo and pureed bread were below 135 degrees F and would follow up on this concern. During an interview with the RD on 5/29/25 at 5:03 p.m., the RD verified that hot foods served to residents should be 135 degrees F or above and would check on that issue. Review of the facility's policy and procedures titled, Food and Dining Services Policies and Procedures: Safe Food Temperatures, effective 2/2009 indicated, Food temperatures are maintained at acceptable levels during food storage, preparation, holding, service, delivery Hot foods will be held at 135 degrees F or higher during meal service (on the tray line) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure, cooking and kitchen equipment were maintained properly and foods in the kitchen were prepared in accordance with professional standards for food safety when: 1. There were unsanitary cooking and kitchen equipment stored in the kitchen and, 2. Kitchen staff did not perform hand hygiene and sanitation during the tray line preparation. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness (illness resulting from contaminated food) and cross-contaminated food for the 55 residents who received food from the facility kitchen. Findings: 1. During the initial kitchen tour observation with the dietary manager (DM), on 5/27/25 at 9:25 a.m., observed 5 large cooking pans with brownish to blackish discolorations and rusty spots in them. During an interview with the DM on 5/27/25 at 9:26 a.m., the DM acknowledged that the 5 large cooking pans had brownish to blackish discolorations and rusty spots and had them removed right away. He then stated that he would have them replaced. During an interview with the registered dietitian (RD), on 5/29/25 at 2:35 p.m., the RD verified that the 5 large cooking pans with brownish to blackish discolorations and rusty spots should not be kept there in the kitchen and should have been replaced. The RD then stated that he would follow-up on that concern. 2. During the tray line preparation observation on 5/28/25 at 12:10 p.m., dietary aide C (DA C) helped in filling out the liquids of the resident meal trays in the tray carts. Observed DA C, went out of the kitchen still wearing her gloves, then went back inside and proceeded to help right away with the tray line preparation without removing her used gloves, doing hand washing and putting on new gloves before going back to helping with the tray line preparation. During an interview with DA C on 5/28/25 at 2:35 p.m., DA C verified that she should have removed her gloves, washed her hands and put on new gloves, before she continued helping with the tray line preparation, when she went out of the kitchen and then came back right after. During an interview with the DM on 5/28/25 at 12:55 p.m., the DM verified that DA C should have removed her used gloves, should have done hand washing and should have put on new gloves after she went out of the kitchen and before helping back with the tray line preparation, when she came back. During an interview with the RD on 5/29/25 at 2:35 p.m., the RD verified the above concern. The RD stated that he would remind the kitchen staffs about proper hand hygiene and sanitation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy and procedure titled, Food and Dining Services Policies and Procedures: Personnel Sanitation Standards, effective 2/2009 indicated, Maintain sanitation among food and dining services personnel. Food and dining services personnel follow sanitary standards and practices . Hands must be washed after each trip to the restroom, after leaving storage rooms, washrooms, etcetera .

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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** 2a. Review of Resident 53's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 53's physician order, dated 5/25/25, indicated she had an order for oxygen 2-3 liters per minute (LPM) as needed for shortness of breath. During an observation and interview with the infection preventionist (IP) on 5/27/25, at 10:46 a.m., the filter of Resident 53's oxygen concentrator was dusty. The IP confirmed the filter was dusty and stated the filter should be cleansed every week. 2b. Review of Resident 112's admission Record indicated he was admitted to the facility on [DATE]. Review of Resident 112's physician order, dated 5/22/25, indicated he had an order for oxygen 2-3 LPM continuous every shift. During an observation and interview with the IP on 5/27/25, at 10:51 a.m., the filter of Resident 112's oxygen concentrator was dusty. The IP confirmed the filter was dusty and stated the filter should be cleansed every week. Review of the facility's policy, Oxygen Concentrator, dated 12/3/24, indicated . 5. Care of the Concentrator: a. Follow manufacturer recommendations for the frequency of cleaning filters and servicing the device. f. Oxygen concentrators should have a preventive maintenance. 3. During an observation on 5/27/25, at 10:12 a.m., certified nursing assistant B (CNA B) put on gloves, picked up trash bag in Resident 12's room, walked out of the room to throw the trash bag in the hamper which was parked on the other side in the hallway with gloves on her hands. CNA B came back to Resident 12's room and prepared his bed with the same gloves on her hands. Resident 12 stated he needed mouth wash. CNA B removed her gloves but did not sanitize her hands, walked out of the room to get mouth wash from the supply room for the resident. During a concurrent interview with CNA B, she stated she should have the hamper at the resident's room door, so she did not have to walk out in the hallway to throw the trash. CNA B stated she should remove her gloves and sanitize her hands when walking out of the resident room and in the hallway. During an interview with the IP on 5/30/25, at 3:02 p.m., she stated staff should not walk out of resident room with gloves on and should sanitize their hands after removing the gloves. 4. During an observation on 5/28/25, at 12:28 p.m., certified nursing assistant A (CNA A) sanitized her hands, put on gloves, moved Resident 212's bed, pulled Resident 212 up, repositioned Resident 212 in bed, and raised Resident 212's head of bed up. CNA A removed her gloves and held the used gloves in her hand. Without sanitizing her hands, CNA A opened the straw and put it in Resident 212's glass of cranberry juice, removed the cover of the fruit cup, removed the lid of the lunch plate, picked up the spoon and pressed on the rice on the lunch plate with the spoon, then walked out of Resident 212's room and in the hallway to place the lid of the plate in the lunch cart without sanitizing her hands. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with CNA A, she stated she should throw the gloves in the trash can, sanitize her hands before assisting the resident with meal and when walking out of the resident room. During an interview with the IP on 5/30/25, at 3:08 p.m., she stated staff should sanitize their hands before assisting the resident with meal and when walking out of the resident room. Review of the facility's policy, Personal Protective Equipment (PPE), dated 6/4/24, indicated . 4. Indications/considerations for PPE use: a. Gloves: . ii. Perform hand hygiene before donning gloves and after removal. Gloves are not a substitute for hand hygiene. iv. Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn. vii. Dispose of gloves in appropriate waste receptacle. Based on observation, interview, and record review, the facility failed to implement infection control measures when: 1. Licensed vocational nurse F (LVN F) did not do hand hygiene in between administration of medications for two residents (Resident 2 and Resident 8); 2. The filters of Resident 53's and Resident 112's oxygen concentrators were dusty; 3. Certified nursing assistant B (CNA B) walked out of Resident 12's room with gloves on and did not sanitize her hands after removing the gloves; and 4. Certified nursing assistant A (CNA A) did not sanitize her hands before assisting Resident 212 with meal and when walking out of the resident room. These failures had the potential to result in the transmission and spread of infection throughout the facility. Findings: 1. During a medication pass observation on 5/28/25 at 4:08 p.m. with Licensed Vocational Nurse (LVN) F, LVN F prepared and administered oral medications to Resident 2. LVN F used gloves and did not do hand hygiene before putting on and after removing gloves. LVN F did not do hand hygiene after administering medications to Resident 2. At 4:13 p.m., LVN F proceeded to prepare and administer oral medications to Resident 8. LVN F did not do hand hygiene prior to administration of medications for Resident 8. LVN F also used gloves for Resident 8 and did not do hand hygiene before wearing and after removing gloves. LVN F verified she did not do hand hygiene in between administration of medications for Resident 2 and Resident 8 and before wearing and after removing gloves. LVN F stated hand hygiene should have been done. During an interview on 5/29/25 at 3:44 p.m. with the Director of Nursing (DON), the DON stated, Hand hygiene must be done during medication pass in between residents. (continued on next page)

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	055646	A. Building B. Wing	05/30/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedure (P&P) entitled, Hand Hygiene revised 5/29/24, the P&P indicated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table: Condition: Between resident contacts- Either soap and water or alcohol-based hand rub Before preparing or handling medications- Either soap and water or alcohol-based hand rub .6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that facility staff monitored and documented the side effects of antibiotic (ATB, medication that fight bacteria) therapy for seven out of 11 residents (Residents 165, 9, 57, 267, 15, 269, and 212) who were receiving antibiotics. This failure had the potential to result in unrecognized adverse drug reactions or inappropriate antibiotic use. Findings: 1. A review of Resident 165's admission record indicated the resident was admitted on [DATE] with diagnoses that included Tuberculosis (TB, an infectitious disease cause by bacteria that primarily affects the lungs) of lung. A review of Resident 165's Order Summary Report indicated that on 5/11/25, the physician ordered the following antibiotics: Levofloxacin (antibiotic used to treat bacteria, including TB) 750 milligrams (mg,unit of measurement) 1 tablet to be given by mouth (PO) daily for pulmonary (lungs) tuberculosis, Ethambutal (antibiotic used to treat TB) 400 mg 3 tablets PO daily for right upper lung (RUL) cavitary lesion (an area of lung tissue damaged by infection) and Linezolid (antibiotic used to treat infection) 600 mg 1 tablet PO daily for RUL cavitary lesion. 2. A review of Resident 9's admission record showed admission on [DATE] with acute and chronic respiratory failure with hypoxia (a condition where the lungs cannot get enough oxygen into the blood), and pneumonia (a lung infection). A review of Resident 9's Order Summary Report indicated the physician ordered Vancomycin (antibiotic used to prevent or treat bacterial infection) 50 mg/ml, 2.5 ml PO daily for prophylaxis (a preventive measure). 3. A review of Resident 57 admission record indicated the resident was admitted on [DATE] with non-rheumatic aortic valve stenosis (a narrowing of the heart's aortic valve that is not caused by rheumatic fever). A review of Resident 57's Order Summary Report indicated the physician ordered Ciprofloxacin (antibiotic used to treat infection) 250 mg PO twice daily for UTI (infections of the bladder or urinary system). 4. A review of Resident 267's admission record indicated resident was admitted on [DATE] with osteomyelitis of the thoracic spine (a serious bone infection in the spine) and discitis in multiple spinal areas (inflammation of the discs between the bones of the spine). A review of Resident 267's Order Summary Report, dated 5/9/25 included Ceftriaxone (antibiotic used for serious infections like bone or spine infections) 2 grams (gm, unit of mass) IV (intravenous, administered into a vein) every 12 hours for discitis (infection in the intervertebral disc space). 5. A review Resident 15's admission record indicated resident was admitted on [DATE] with chronic obstructive pulmonary disease (COPD, a long-term lung disease that makes it hard to breathe.) (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Antibiotic List dated 5/2025 showed that on 5/28/25, the physician ordered Cefdinir (an oral antibiotic used to treat respiratory tract infections, including pneumonia) 300 mg PO twice daily for pneumonia. 6. A review of Resident 269's admission record indicated resident was admitted on [DATE] with aftercare following a liver transplant (surgical procedure where a diseased or damaged liver is removed and replaced with a healthy liver from a donor) and cirrhosis of the liver (a condition where the liver is permanently scarred and cannot function well). A review of the facility's Antibiotic List, indicated that on 5/21/25, Resident 269 was prescribed Bactrim (antibiotic used to prevent bacterial infections) 400-80 mg via nasogastric (NG, means the medication is given through a tube from the nose to the stomach) every Mon, Wed, and Fri as prophylaxis for organ transplant. During an interview on 5/29/25 at 4:10 p.m., registered nurse (RN) G stated that nurses assess for rash, hives, dizziness, or other side effects during antibiotic therapy, and that documentation should be entered in the MAR (medication administration record) or progress notes. During a concurrent interview and record review with RN H , evening supervisor, on 5/29/25 at 4:15 p.m., RN H stated that facility staff check for allergic reactions, nausea, vomiting, or changes in cognition, and this should be documented. RN H confirmed no documentation was found for side effect monitoring for the residents listed above. During an interview with the Infection Preventionist (IP) on 5/29/25, at 4:33 p.m., the IP stated that nurses should monitor for side effects while residents are on antibiotics and document those findings. During an interview with the Director of Nursing (DON) on 5/29/25 at 4:40 p.m., the DON confirmed that there was no documentation of antibiotic monitoring in the MAR or progress notes for the above residents. The DON stated that monitoring for side effects should be documented in the progress notes. The DON further stated that she would educate nursing staff regarding proper documentation of antibiotic therapy monitoring. 7. During an observation of Resident 212 on 5/27/25 at 10:27 a.m., Resident 212 was laying in his bed, alert, calm, comfortable and verbally responsive. Review of Resident 212's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 212 was admitted to the facility on [DATE]. Review of Resident 212's order summary report dated 5/29/25 indicated, Resident 212 had an order of Ciprofloxacin Hydrochloride (antibiotic used to treat bacterial infections) oral tablet, 500 milligrams (mg, unit of mass), give 1 tablet by mouth two times a day for urinary tract infection (UTI, an infection that occurs in any part of the urinary system or the system of organs that makes urine), for 7 days, started on 5/23/25. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent review of Resident 212's clinical records and interview with licensed vocational nurse D (LVN D), on 5/30/25 at 9:43 a.m., LVN D verified that Resident 212 did not have any progress notes (type of medical record used to document a patient's health status and treatment progress) for his use of Ciprofloxacin Hydrochloride antibiotic, since it was started on 5/23/25. During a concurrent review of Resident 212's clinical records and interview with the DON, on 5/30/25 at 1:10 p.m., the DON verified that Resident 212 was on Ciprofloxacin Hydrochloride antibiotic but there was no progress notes and no monitoring for the side effects of the antibiotic use. The DON further verified that she would follow up on this concern. Review of the facility's policy titled, Antibiotic Prescribing Practices, reviewed/revised on 5/29/24 indicated, Antibiotic use protocols, including prescribing practices, are implemented as part of the facility's Antibiotic Stewardship Program for the purpose of optimizing the treatment of infections and reducing adverse events associated with antibiotic use .Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation and interview, the facility failed to ensure 17 of 27 bedrooms had at least 80 square feet per resident. Having less than 80 square feet per resident could potentially compromise the care and services the residents receive. Findings: The room measurement indicated multiple rooms were less than 80 square feet per resident. Room Number Number of Beds Square Feet Per Resident 1 3 72.8 5 2 71.37 7 2 71.95 9 2 75 12 3 73.2 14 3 73.2 15 3 73.2 16 3 74 17 3 74 18 2 75 19 2 73.2 20 2 74.4 23 3 73.2 24 3 73.6 25 3 73.6 27 3 73.6 29 3 73.2 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During the survey, residents and staff were observed and interviewed to determine if there were any concerns or issues with the lack of space or privacy. The residents and staff verbalized no complaints or concerns regarding space and privacy affecting residents' care. Recommend to continue room waivers.