STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the staff provided care and promoted dignity and respect for three of 11 residents reviewed for dignity and respect (Residents 5, 8, and 35). * CNA 3 was observed standing over Resident 8 while assisting the resident with meals. * CNA 2 was observed standing over Resident 35 while assisting the resident with meals. * The facility failed to ensure Resident 5's body was fully covered while being transported from the shower room to her room. These failures had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Assistance with Meals revised July 2017 showed the residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: not standing over residents while assisting them with meals. 1. During the dining observation on 4/2/24 at 1233 hours, CNA 3 was observed standing over Resident 8's right side of the bed while assisting on feeding Resident 8's lunch meal. Medical record review was initiated on 4/2/24. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 10/3/23, showed Resident 8 could make needs known but not make medical decisions. On 4/2/24 at 1242 hours, an interview was conducted with CNA 3. CNA 3 stated standing was harder while feeding Resident 8 due to her bed. CNA 3 stated Resident 8 would see her better if she was standing. CNA 3 stated the staff was suppose to sit while assisting on feeding the residents. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 1249 hours, an interview was conducted with the DSD. The DSD stated the staff needed to prompt the residents up to prepare for meal if required assistance with their meals. The DSD further stated the staff was supposed to sit with eye level and talk to the residents who required assistance with their meal. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings. 2. On 4/3/24 at 0828 hours, CNA 2 was observed standing over Resident 35 while assisting in feeding Resident 35 with her breakfast meal. Medical record review for Resident 35 was initiated on 4/3/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 5/10/23, showed Resident 35 had the capacity to understand and make decisions. On 4/3/24 at 0832 hours, an interview was conducted with CNA 2. CNA 2 stated when she had time, she would sit. CNA 2 verified she was supposed to sit while feeding the residents with their meals. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings. 44175 3. Review of the facility's P&P titled Resident Rights revised 2016 showed employee shall treat all the residents with kindness, respect, and dignity. Further review of the P&P showed federal and state laws guarantee certain basic rights to all residents of the facility, the rights included the resident right to a dignified existence, privacy and confidentiality. On 4/5/24 at 1020 hours, CNA 4 was observed wheeling Resident 5 in a shower chair into Resident 5's room. Resident 5's hair was observed wet, and a white blanket was under Resident 5's chin covering her chest, arms, and legs. The blanket was observed not fully covering Resident 5's left side of her body exposing about 10 to 12 inches of Resident 5's lower back, hip, and upper thigh. Medical record review for Resident 5 was initiated on 4/5/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 10/3/23, showed Resident 5 had the capacity to understand and make decisions. Review of Resident 5's MDS dated [DATE], showed Resident 5 was cognitively intact. On 4/5/24 at 1021 hours, the Administrator and CNA 4 verified the above observation in Resident 5's room while Resident 5 sat on the shower chair. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/2024 at 1021 hours, an interview was conducted with the Administrator. The Administrator confirmed the resident's buttock area was uncovered with the blanket and exposed. The Administrator confirmed Resident 5 was wheeled from the shower room to the resident's room, which was about 40 feet away and involved wheeling the resident pass the nurses station with several staff at the station and Resident 12 sitting in the hallway across the nurses' station. Resident 12 was alert and oriented. The Administrator stated the resident's buttock area should not have been uncovered to honor the resident's dignity. On 4/5/24 at 1115 hours, an interview with Resident 5 was conducted. Resident 5 stated she did not know her back, buttock, hip, and thigh area uncovered while she was in the shower chair and wheeled from the shower room to her room. Resident 5 stated it made her feel embarrassed to hear that her body was not fully covered while in the hallway and she needed to be covered to ensure her modesty was protected.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to fully inform the resident or responsible party of their bed with side rails, the entrapment assessment for Zone 6, and the treatment alternatives or options for two of four sampled residents (Residents 9 and 32). This failure had the potential for Residents 9 and 32 and their responsible parties to not make the informed decisions regarding the care and treatment of bed side rail use. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Rails showed residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Proper Use of Side Rails revised on 12/2016 showed an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. The risks and benefits of side rails will be considered for each resident. The P&P further showed consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. (Note: Federal regulations do not require written consent for using restraints. Signed consent forms do not relieve the facility from meeting the requirements for restraint use, including proper assessment and care planning. While the resident or family (representative) may request a restraint, the facility is responsible for evaluating the appropriateness of that request). Moreover, the P&P showed the resident will be checked periodically for safety relative to side rail use. Review of the facility's P&P titled Bed Safety revised on 12/2007 showed the resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Furthermore, the P&P showed when using side rails for any reason, the staff shall take measures to reduce related risks and if side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the attending physician, and input from the resident and/or legal representative. Review of the facility's P&P titled Resident Rights revised 12/2016 showed the residents have the right to be informed of and participate in, his or her care planning and treatment. Review of the facility's document titled Safety Assessment for Siderail Usage showed Zone 6 measurements was between the end of the rail and the side edge of the head or foot board or any V-shaped opening between the end of the rail and the head or foot board (risk of entrapment due to wedging). 1. Medical record review for Resident 9 was initiated on 4/2/24. Resident 9 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of the facility's document titled Side Rail Order (undated) showed Resident 9 had the left 1/2 (half) side rail padded. Review of the facility's document titled Bed Inspection (Measurement) dated 1/3/24, showed Bed Number 27 was assigned to Resident 9 and had failed Zone 6 measurement. Further review of Resident 9's medical record showed the resident had a consent for a padded left side rail dated 9/14/23. On 4/2/24 at 0842 hours, an initial tour of the facility was conducted. Resident 9 was observed in bed with padded left side rail. Resident 9 was observed able to move the upper extremities. On 4/4/24 at 1602 hours, a concurrent interview and facility document review with the Administrator was conducted. The Administrator verified Resident 9's bed had a failed Zone 6 measurement as documented on the facility document titled Bed Inspection (Measurement) dated 1/3/24. When asked if the resident or the resident's family member was notified and made aware of the failed Zone 6 measurement, the Administrator stated they were not. The Administrator further stated he could not provide documented evidence Resident 9's or family were notified of the failed Zone 6 measurement. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged above findings. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference to F909 for example #2. 44175 2. On 4/2/24 at 0824 hours, an observation and concurrent interview was conducted with Resident 32. Resident 32 was observed laying in bed, alert and awake, and the bilateral half side rails were observed elevated. Resident 32 stated he did not use the side rails that attached to the bed since he got admitted in the facility. On 4/4/24 at 0723 hours, a concurrent observation and interview was conducted with LVN 1. Resident 32 was observed alert, awake in bed with bilateral half side rails elevated. LVN 1 verified the observation. Medical record review for the Resident 32 was initiated on 4/2/24. Resident 32 was admitted to the facility on [DATE]. Review of the Resident 32's MDS dated [DATE], showed Resident 32 was cognitively intact. Review of Resident 32's Physician Order Summary dated 4/2/24, showed the physician's order for bilateral half side rails up when in bed for mobility and repositioning. On 4/4/24 at 0833 hours, an interview and concurrent medical record review for Resident 32 was conducted with the IP. When asked about the bed inspection process, the IP stated she and the Administrator checked if there was a gap between the mattress and side rails, using the bed system measurement device annually. When asked if she and the Administrator inspected the bed when the side rails were initially ordered and installed. The IP stated the facility only conducted the bed inspection annually. The IP stated when the new resident admitted to a bed with the siderails attached and if the resident requested the side rails to be elevated, then she looked back to the measurements and determine for possible entrapment risk. Review of the Bed Inspection (Measurements) dated 1/3/24, showed, Bed #15. The IP verified Bed #15 corresponded to the bed that Resident 32 was currently using, to which she and the Administrator had checked the bedframe length, mattress length, mattress height, zone passed, and zone, which failed for the use of the siderails. Further review of the document showed Bed #15 failed Zone 6. Review of Resident 32's medical record titled Facility Verification of Informed Consent dated 4/2/24, for the use of bilateral half side rails did not show if Resident 32 was notified of Zone 6 of the bed failed the inspection. The IP verified the above findings and stated Resident 32 was notified of the overall entrapment risk for the use of siderails; however, the IP was not able to show if Resident 32 was notified of the bed failed for the Zone 6 entrapment assessment. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1346 hours, an interview and concurrent record review was conducted with the Administrator. The Administrator verified the above findings and stated Resident 32's bed failing Zone 6 entrapment assessment meant there was a risk that Resident 32's head might get entrapped in that zone. The Administrator stated an informed consent was obtained from Resident 32 explaining the overall entrapment risk for the use of siderails; however, he was not able to show if Resident 32 was informed of his bed measurement failing on entrapment Zone 6 and risk of possible entrapment in that zone. On 4/4/24 at 1626 hours, an interview was conducted with the DON. The DON acknowledged above findings. Cross reference to F909 for example # 1.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the care needs for one nonsampled residents of 38 residents in the facility (Resident 37). * The facility failed to ensure Resident 37's call light was within the resident's reach. This failure had the potential to negatively impact the resident's psychosocial well-being or result in a delay to provide care and services to the resident. Findings: Review of the facility's P&P titled Call System, Resident revised September 2022 showed each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting and bathing facilities and from the floor. During the initial tour on 4/2/24 at 0807 hours, Resident 37's call light was observed on the floor on the right side of her bed. Medical record review for Resident 37 was initiated on 4/2/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's H&P examination dated 9/25/23, showed Resident 37 had no capacity to understand and make decisions. Review of Resident 37's MDS dated [DATE], showed the following: -roll left and right in bed was coded 01, which meant dependent assistance and helper would do all the effort; and -chair/bed-to-chair transfer was coded 01, which meant dependent assistance and helper would do all the effort. On 4/2/24 at 0811 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 37's call light was on the floor. CNA 1 stated she did not notice Resident 37's call light was on the fall when she raised her bed. CNA 1 stated the call light should be within the resident's reach. On 4/3/24 at 0745 hours, an interview was conducted with the DON. The DON stated her expectation was for the call lights to be answered within two minutes and the call lights should always be within the resident's reach.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one resident (Resident 26) reviewed for resident's choice and food preferences with meals was honored. This failure had the potential risk for a diminished quality of life and impact resident's well-being. Findings: Review of the facility's P&P titled Resident Food Preferences revised July 2017 showed when possible, the staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Review of the facility's P&P titled Resident's Rights revised December 2016 showed Federal and State laws guarantee certain basic rights to all residents to this facility. These rights include the resident's right to: e. self-determination. During the dining observation on 4/2/24 at 1253 hours, Resident 26 was observed sitting up in his wheelchair in the dining room with his lunch meal tray in front of him. Resident 26's plate was observed with untouched white rice. Resident 26 stated he did not like rice. Resident 26 stated he had not eaten rice for two years. Resident 26's meal tray ticket was observed and showed fortified diet, no added salt (NAS), mechanical soft texture, lactose free and no corn, zucchini, rice, wheat bread, and lettuce for lunch as his preference. Medical record review for Resident 26 was initiated on 4/2/24. Resident 26 was readmitted to the facility on [DATE]. Review of Resident 26's H&P examination dated 10/7/23, showed Resident 26 had the capacity to understand and make decisions. Review of Resident 26's Nutritional Screening and assessment dated [DATE], showed the resident's food dislikes were liver, corn, squash, zucchini, egg noodles, grits, and rice. On 4/2/24 at 1255 hours, an observation and concurrent interview was conducted with the SSD. The SSD verified there was untouched rice on Resident 26's plate and his meal ticket showed no rice as his preference for lunch. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview, medical record review, and facility P&P review, the facility failed to inform and provide the written information regarding the rights to formulate the advance directives to one of three reviewed residents (Resident 35). In addition, the facility failed to ensure the copy of the advance directives was readily available in the residents' charts for two of three reviewed residents for advance directives (Residents 10 and 12). These failures had the potential for the facility to provide treatment and services against the resident's wishes. Findings: Review of the facility's P&P titled Advance Directives revised December 2016 showed upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Written information will include a description of the facility's policies to implement advance directives and applicable state law. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative had already been given the information. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 1. Medical record review for Resident 35 was initiated on 4/3/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 5/10/23, showed Resident 35 had the capacity to understand and make decisions. Review of Resident 35's POLST dated 5/10/23, showed Resident 35 had no advance directive. Further review of Resident 35's medical record did not show documented evidence Resident 35 acknowledged she was offered and received the information regarding the formulation of an advance directive or having an advance directive. On 4/3/24 at 0846 hours, an interview was conducted with the SSD. The SSD stated upon a resident's admission, she would see the resident's H&P examination if the resident had the capacity to understand and make decision. The SSD stated she would interview the residents regarding the advance directive if the resident had an advance directive or request to formulate one. The SSD stated if the resident had an advance directive, she would request a copy from the resident or the resident's family members to place in the resident's medical record. The SSD stated if the resident requested to formulate an advance directive, she would then assist the resident by providing and explaining information about the advance directive and contact the Ombudsman to further assist the resident for the completion of formulating an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 at 0858 hours, a follow-up interview and concurrent medical record review was conducted with the SSD. The SSD verified the above findings and stated she was not able to provide documentation to show she had offered and provided the information about the formulation of an advance directive to Resident 35. 2. Medical record review for Resident 10 was initiated on 4/2/24. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 2/3/24, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's POLST under Section D dated 2/5/24, showed Resident 10 had an advance directive available. Further review of Resident 10's medical record did not show a copy of advance directive. On 4/3/24 at 0846 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD showed a copy of Resident 10's advance directive. However, the SSD had Resident 10's copy of advance directive in a separate binder in her office drawer. The SSD reviewed Resident 10's electronic and paper medical record and did not find a copy of Resident 10's advance directive. The SSD stated Resident 10 was sent in the hospital and the copy of the resident's advance directive was not placed back in his new medical record. The SSD stated the copy of Resident 10's advance directive should be readily accessible in the resident's medical record. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings. 44175 3. Medical record review for Resident 12 was initiated on 4/2/24. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 1/11/24, showed Resident 12 had the capacity to understand and make decisions. Review of the MDS dated [DATE], showed Resident 12 was cognitively intact. Review of Resident 12's POLST dated 1/10/24, showed Resident 12's advance directive was not available. Review of Resident 12's Psychosocial assessment dated [DATE], showed Resident 12 had a power of attorney and the resident's family member to provide the copy to the facility. Further review of Resident 12's medical record failed to show a copy of Resident 12's advance directive and the facility had followed up with the resident's family member to have a copy of the advance directive in file readily available. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 0920 hours, an interview and a concurrent record review was conducted with the SSD. The SSD verified the above findings and stated during the initial care plan meeting, Resident 12's family member informed her that Resident 12 had an advance directive, and she requested the copy of advance directive. The SSD stated the social services staff was responsible for obtaining the copies of the advance directives from the resident or their families. The SSD was not able to verify if she followed up to obtain a copy of the advance directive from Resident 12's family member. The SSD acknowledged she should have followed up with Resident 12's family member to obtain a copy of the advance directive readily available in file. On 4/4/24 at 1626 hours, an interview was conducted with the DON. The DON acknowledged above findings.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility P&P review, the facility failed to notify the resident and/or their representative of the transfer/discharge and reasons for the transfer in writing for one of five residents reviewed for hospitalization (Resident 32). This failure had the potential for the resident and their representative not knowing about the appeal process should the resident and their representative believe the transfer or discharge was inappropriate or involuntary. Findings: Review of the facility's P&P titled Transfer or Discharge Notice revised December 2016 showed the facility shall provide a resident and/or the resident representative with a 30 day written notice of an impending transfer or discharge. The notice will be given as soon as it is practicable but before the transfer or discharge when an immediate transfer or discharge is required by the resident urgent medical needs. Further review of the P&P showed the resident and/or representative will be notified in writing of the information which included following: - The reason for transfer or discharge; - The effective date of the transfer or discharge; - The location to which the resident is being transferred or discharged ; - A statement of the resident's right to appeal the transfer or discharge including; - Name address, email and telephone number of the entity which receives such request; - Information on how to obtain complete and submit an appeal form; and - How to get assistance completing the appeal process. Medical record review for Resident 32 was initiated on 4/2/24. Resident 32 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 32 's H&P examination dated 2/3/24, showed Resident 32 had the capacity to understand and make decisions. Review of Resident 32's Physician's Order dated 1/17/24, showed an order for bed hold for seven days, Resident 32 was transferred from the medical appointment to acute care hospital. Review of Resident 32's Progress Note dated 1/17/24 at 1816 hours, showed the facility contacted Resident 32 on his cell phone to ask for the status of his medical appointment when he did not return to the facility, and Resident 32 informed the facility that he was being admitted to the acute care hospital for his medical need. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 32's medical record did not show if Resident 32 and/or their representative were provided notification of the transfer and reasons for the transfer in writing. On 4/4/24 at 1440 hours, an interview was conducted with the SSD. The SSD stated she was responsible to provide the written notification of the transfer discharge to the resident and/or their representative. The SSD verified the above findings and stated the facility did not provide the written notification to Resident 32 and/or their representative when he was transferred to the acute care hospital from his routine medical appointment. The SSD stated she should have provided the written notification and reason for the transfer in writing to Resident 32 and/or the resident's representative. On 4/4/24 at 1626 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview, medical record review, and facility P&P review, the facility failed to notify five of five residents reviewed for bed hold notification (Residents 10, 22, 32, 35, and 38) of their rights to a bed hold (holding or reserving a resident's bed while the resident in the acute care hospital) policy upon transfer to the acute care facility. This failure had the potential for residents or their representatives to be unaware of his or her rights to request a bed hold upon transfer. Findings: Review of the facility's P&P titled Bed-Holds and Returns revised March 2017 showed prior to transfer and therapeutic leaves, the residents or resident representatives will be informed in writing of the bed-hold and return policy. The policy interpretation and implementation states that residents may return to and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy. Prior to transfer, written information will be given to the residents and the resident representative that explains in detail: a. The rights and limitations of the resident regarding bed-holds. b. The reserve bed payment policy as indicated by the state plan (Medicaid residents) c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer). 1. Medical record review for Resident 10 was initiated on 4/2/24. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 2/3/24, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Physician's Order dated 1/29/24, showed may transfer Resident 10 to Hospital A via 911 for further evaluation, and bed hold for seven days if admitted . Review of Resident 10's Notice of Transfer/discharge date d 1/29/24, showed Resident 10 was transferred to Hospital A. Review of Resident 10's General Nurses' Notes for January 2024 did not show documented evidence Resident 10 or his representative was provided information about the bed hold policy or their rights to request for bed hold upon transfer to an acute hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 1102 hours, an interview was conducted with LVN 1. LVN 1 stated when a resident was transferred to the acute hospital, the licensed nurse prepared a packet containing the resident's medical information, notify the physician and receive an order to transfer the resident and a bed hold for seven days if the resident was admitted to the acute hospital. 2. Medical record review for Resident 22 was initiated on 4/3/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 3/21/24, showed Resident 22 had the capacity to understand and make decisions. Review of Resident 22's Physician's Order showed the following orders: - dated 1/9/24, to transfer Resident 22 to Hospital B emergency department for left hip hemiarthroplasty (a surgical operation that replaces half of a joint with an artificial replacement and leaves the other part in its natural state), and bed hold for seven days if admitted . - dated 3/16/24, to transfer Resident 22 to Hospital B with orthopedic doctor (examines, diagnoses, and treats diseases and injuries to the musculoskeletal system) for left hip replacement due to broken hip and failed screws. Review of Resident 22's General Nurses' Notes for January and March 2024 did not show documented evidence Resident 22 or her representative was provided with the information about the bed hold policy or their rights to request for bed hold upon transfer to an acute hospital. On 4/4/24 at 1523 hours, an interview and concurrent medical record review was conducted with the MDS Nurse. The MDS Nurse verified the above findings. The MDS Nurse stated when a resident was transferred to the emergency department, the bed hold should be offered to the resident or resident's representatives. 3. Medical record review for Resident 35 was initiated on 4/3/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 5/10/23, showed Resident 35 had the capacity to understand and make decisions. Review of Resident 35's Physician's Order, showed the following orders: - dated 10/3/23, to transfer Resident 35 to Hospital A and bed hold for seven days of admitted . - dated 2/7/24, to transfer Resident 35 to Hospital A for further evaluation and bed hold for seven days if admitted . Review of Resident 35's General Nurses' Notes for December 2023 and February 2024 did not show documented evidence Resident 35 or her representative was provided with the information about the bed hold policy or their rights to request for the bed hold upon transfer to an acute hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 1317 hours, an interview and concurrent record review was conducted with the MDS Nurse. The MDS Nurse verified and acknowledged the above findings. On 4/5/24 0839 hours, an interview was conducted with the DON. The DON verified the above findings and stated the facility did not have a bed hold notification form and they only had a notice of transfer or discharge form that was completed when a resident was discharged from the facility. 44175 4. Medical record review for Resident 32 was initiated on 4/2/24. Resident 32 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of the H&P examination dated 2/3/24, showed Resident 32 had the capacity to understand and make decisions. Review of the Resident 32's Physician Order dated 1/17/24, showed an order for bed hold for 7 days, Resident 32 was transferred to from medical appointment to acute care hospital. Review of the Resident 32's General Nurses Notes dated 1/ 17/24 at 1816 hours, showed the facility contacted Resident 32 on his cell phone to ask about the status of his medical appointment when he did not return to the facility, and Resident 32 informed facility that he was being admitted to the acute care hospital for his medical need. Further review of the progress notes showed Resident 32 was put on bed hold. Further review of Resident 32's medical record did not show if Resident 32 and/or their representative were provided with the written information regarding the facility's bed-hold policy. On 4/4/24 at 1415 hours, an interview and concurrent record review was conducted with the RN 1. RN 1 was not able to show if Resident 32 was provided with the written information regarding the facility's bed-hold policy when he was transferred to the acute care hospital on 1/17/24. On 4/4/24 at 1420 hours, an interview and concurrent record review was conducted with the SSD. The SSD verified the above findings and stated the facility did not provide Resident 32 and/or their responsible party the written information regarding the facility's bed-hold policy. On 4/4/24 at 1626 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 48332 5. Medical record review of Resident 38 was initiated on 4/05/24. Resident 38 was admitted to the facility on [DATE], and transferred to the acute care hospital on 3/26/24. Review of Resident 38's MDS dated [DATE], showed Resident 38's cognitive skills for daily decision making were severely impaired. Review of Resident 38's Physician Discharge Summary dated 3/26/24, showed Resident 38 was transferred to acute for GT placement. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 38's Notice of Transfer / Discharge form dated 3/26/24, showed Resident 38 was to be transferred to the acute care hospital. Further review of the form failed to show the written notice of the bed hold was provided to Resident 38's responsible party. On 4/05/24 at 0922 hours, an interview and concurrent record review was conducted with Business Office Manager. The Business Office Manager verified Resident 38 was transferred to the acute hospital on 3/26/24. The Business Office Manager was asked to show the documentation that Resident 38 or the responsible party was notified in writing of the bed hold policy at the time of transfer to the acute care hospital. The Business Office Manager stated the facility did not have the bed hold notification to notify Resident 38 or responsible party of bed hold policy. On 4/05/24 at 0942 hours, an interview was conducted with DON. The DON verified there was no bed hold notification form to notify Resident 38 and/or responsible party of the bed hold.

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview and medical record review, the facility failed to ensure the quarterly MDS assessment was completed within 14 calendar days of the Assessment Reference Date (ARD) for one of one reviewed resident (Resident 21). This failure had the potential of not identifying each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessments once the health problems had been identified. Findings: Review of the Long-Term Facility Resident Assessment Instrument 3.0 User's Manual v1.18.11 dated October 2023 showed a Quarterly (Non-Comprehensive) assessment completion date must be no later than 14 calendar days of the MDS assessment's ARD and data submission must be no later than 14 days of the assessment's completion date. Medical record review for Resident 21 was initiated on 4/3/24. Resident 21 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 21's MDS Quarterly assessment dated [DATE], showed the assessment was initiated. However, Resident 21's MDS Quarterly Assessment showed it was open and not submitted. On 4/3/24 at 1611 hours, an interview and concurrent medical record review was conducted with the MDS Nurse. The MDS Nurse verified Resident 21's MDS quarterly assessment had an ARD of 2/19/24, and had an open status. The MDS Nurse stated when the assessment status showed open, it meant the assessment was not completed. The MDS Nurse stated Resident 21's MDS quarterly assessment should had been completed 14 days after the ARD on 3/4/24. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview and medical record review, the facility failed to transmit the MDS timely for one of one resident reviewed (Resident 14). This failure had the potential for not providing care to meet the resident's care needs. Findings: Review of the Long-Term Facility Resident Assessment Instrument 3.0 User's Manual v1.18.11 dated October 2023 in Chapter 5: Submission and Correction of the MDS Assessments, Section 5.2, showed a Quarterly (Non-Comprehensive) Review Assessment data submission must be no later than 14 days of the assessment's completion date. Medical record review for Resident 14 was initiated on 4/3/24. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's MDS Quarterly assessment dated [DATE], showed the assessment with a completion date of 2/28/24. Review of the MDS 3.0 Nursing Home (NH) Final Validation Report showed Resident 14's MDS Quarterly assessment dated [DATE], with submission date and time of 3/28/24 at 1255 hours. On 4/3/24 at 1630 hours, an interview and concurrent interview was conducted with the MDS Nurse. The MDS Nurse stated she was not the person submitting the residents' assessments to CMS. The MDS Nurse stated a person from the corporate submitted the residents' assessments to CMS. The MDS Nurse stated Resident 14's MDS quarterly assessment dated [DATE], should had been submitted on 3/13/24. On 4/4/24 at 0844 hours, the MDS Nurse provided documents to show Resident 14's MDS quarterly assessment dated [DATE], was submitted on 3/28/24, and stated the assessment was submitted late. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above finding.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview and medical record review, the facility failed to ensure the MDSs for 11 of 17 reviewed residents (Residents 3, 15, 16, 18, 19, 21, 23, 25, 27, 31, and 33) were accurate. This failure posed the risk of the residents not receiving an individualized plan of care on the residents' specific needs. Findings: Review of the Long-Term Facility Resident Assessment Instrument 3.0 User's Manual v1.18.11 dated October 2023 in Chapter 3 under Section O0300: Pneumococcal Vaccine, showed Up to date in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations. For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at - https://www.cdc.gov/vaccines/schedules/hcp/index.html - http://www.cdc.gov/vaccines/hcp/acip-recs/index.html - https://www.cdc.gov/pneumococcal/vaccination.html Review of the new CDC guideline titled (MMWR) Morbidity and Mortality Weekly Report dated 1/28/22, showed use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine among U.S. Adults: Updated Recommendations of the Advisory Committee on Immunization Practices (APIC) - United States, 2022. Review of the CDC guidelines for pneumococcal vaccination reviewed 9/22/23, showed the following: - for adults [AGE] years or older who had never received any pneumococcal vaccine regardless of risk conditions, give one dose of PCV 15 or PCV 20. When PCV 15 is used, it should be followed by a dose of PPSV 23 at least one year later. The minimum interval (eight weeks) can be considered in adults with an immunocomprising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will the be complete. When PCV 20 is used, it does not need to be followed by a dose of PPSV 23. Their vaccines are then completed. - for adults [AGE] years or older who had only received PPSV 23 regardless of risk condition, give 1 dose of PCV 15 or PCV 20 at least one year after the most recent PPSV 23 vaccination. Regardless of vaccine given, an additional dose of PPSV 23 is not recommended since they already received it. Their vaccines are then completed. 1. Medical record review for Resident 21 was initiated on 4/3/24. Resident 21 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 21's Resident Immunization Record form (undated), showed Resident 21 received the Pneumococcal polysaccharide vaccine (PPV) on 9/10/20, prior to admission to the facility. Resident 21's Pneumococcal Pneumonia Immunization Program Consent Form was not completed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 21's MDS dated [DATE], showed Section O0300A with a question if the resident's pneumococcal vaccination up to date and was coded yes. On 4/9/24 at 1415 hours, an interview and concurrent medical record review was conducted with the IP. The IP stated she should have offered Resident 21 the option to receive the Pneumococcal Conjugate Vaccine 20 (PCV 20) to be up to date with her pneumococcal immunization. On 4/10/24 at 1236 hours, an interview and concurrent medical record review was conducted with the DON and IP. The DON and IP verified the above findings, and they stated the MDS was not up to date regarding Resident 21's pneumococcal immunization. 2. Medical record review for Resident 25 was initiated on 4/9/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Resident Immunization Record form (undated), showed Resident 25 received a pneumonia vaccination on 5/10/22. However, the form did not show what type of pneumococcal vaccination was administered to Resident 25. Review of Resident 25's MDS dated [DATE], showed Section O0300A with a question if the resident's pneumococcal vaccination up to date and was coded yes. On 4/9/24 at 1348 hours, an interview and concurrent medical records was conducted with the IP. The IP stated Resident 25's pneumococcal vaccination history information should had been unknown. The IP stated she only offered the residents the option to receive the Pneumococcal polysaccharide vaccine 23 (PPV 23) because it was the only pneumococcal vaccination listed in the Pneumococcal Pneumonia Immunization Program Consent Form. The IP stated she should had offered the PCV 20 for Resident 25 be up to date with her pneumococcal immunization. On 4/10/24 at 1233 hours, an interview and concurrent medical record review was conducted with the DON and IP. The DON and IP verified the above findings, and they stated the MDS Nurse was not up to date regarding Resident 21's pneumococcal immunization. On 4/10/24 at 1253 hours, an interview was conducted with the MDS Nurse. The MDS Nurse stated the IP told her if the resident did not have a pneumonia vaccine for the past five year, the MDS Nurse would notify the IP to offer the pneumonia vaccine. The MDS Nurse further stated she received the most updated information about immunization from the IP. Cross reference to F883 for examples #9 and #10. 44175 3. Medical Record Review for Resident 3 was initiated on 4/3/24. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's Immunization Administration Record showed Resident 3 received pneumococcal vaccine on 3/6/20. The Immunization Administration Record for Resident 3 did not show the type of the pneumococcal vaccine received. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's MAR dated March 2020 showed Resident 3 had received PPSV23 on 3/6/20. Review of the Resident 3's General Nurses Note dated 4/8/24 at 1733 hours, showed the resident's responsible party was called and offered PCV 20, educated on pneumococcal vaccination, and declined the vaccination. Further review of Resident 3's medical record did not show if Resident 3 was offered PCV 20 single dose or PCV 15 followed by PPSV 23, until 4/8/24. Review of Resident 3's MDS dated [DATE], showed Section O0300A with a question if the resident's pneumococcal vaccination up to date, and was coded yes. 4. Medical record review for Resident 16 was initiated on 4/9/24. Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 16's MAR dated June 2021 showed Resident 16 had received PPSV23 on 6/10/21. Further review of the medical record for Resident 16 did not show if Resident 16 was offered PCV 20 single dose or the PCV 15 followed by PPSV 23. Review of Resident 16's MDS dated [DATE], showed Section O0300A with a question if the resident's pneumococcal vaccination up to date, and was coded yes. 5. Record review for Resident 19 was initiated on 4/9/24. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's undated Immunization Administration Record showed Resident 19 had received Pneumococcal vaccine on 6/11/21, and PCV 20 on 4/6/24. The Immunization Administration Record for Resident 19 did not show the type of pneumococcal vaccine received on 6/11/21. Review of Resident 19's MAR dated June 2021 showed Resident 19 received PPSV23 on 6/11/21. Further review of Resident 19's medical record did not show if Resident 19 was offered PCV 20 single dose or the PCV 15 followed by PPSV23, until 4/6/24. Review of Resident 16's MDS dated [DATE], showed Section O0300A with a question if the resident's pneumococcal vaccination up to date, and was coded yes. 6. Medical record review for Resident 23 was initiated on 4/9/24. Resident 23 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 23's undated Immunization Administration Record showed Resident 23 had received pneumococcal vaccine on 5/10/22, and PCV 20 on 4/6/24. The Immunization Administration Record for Resident 19 did not show the type of pneumococcal vaccine received on 5/10/22. Review of Resident 23's MAR dated May 2022 showed Resident 23 received PPSV 23 on 5/10/22. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 23's medical record did not show if Resident 23 was offered PCV 20 single dose or the PCV 15 followed by PPSV 23, until 4/6/24. Review of Resident 23's MDS dated [DATE], showed Section O0300A with a question if the resident's pneumococcal vaccination up to date, and was coded yes. 7. Medical record review for Resident 27 was initiated on 4/9/24. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's undated Resident Immunization Record did not show an entry for the pneumococcal vaccination. Review of Resident 27's General Nurses Note dated 2/14/24, showed the facility called the resident's responsible party to inquire about the vaccination status and was awaiting for a call back from the responsible party. Further review of the medical record for Resident 27 did not show if the facility followed up with the responsible party to inquire about Resident 27's pneumococcal vaccination status after 2/14/24, and if a pneumococcal vaccination was offered to the Resident 27. Review of Resident 27's MDS dated [DATE], showed Section 0300B showed with a question if pneumococcal vaccine not received state reason, and was coded offered and declined. On 4/9/24 at 1447 hours, a concurrent interview and medical record review for Residents 3, 16, 19, 23, and 27 was conducted with the IP. The IP verified the above findings. The IP stated Residents 3, 16, 19, and 23 did not receive the updated vaccination which was either PCV20 single dose, or PCV15 followed by PPSV 23 to be up to date with their pneumococcal immunization until 4/6/24. The IP stated she inquired about Resident 27's vaccination status and received an email from the previous facility that Resident 27 declined the pneumococcal vaccination; however, she did not offer the pneumococcal vaccination in the facility. The IP further stated Residents 3 and 19 received the updated pneumococcal vaccine PCV20 on 4/6/24, and Resident 3's responsible party had declined the offer for the pneumococcal vaccination on 4/8/24, and she was working to provide the updated pneumococcal vaccination to the other residents. On 4/10/24 at 1234 hours, a concurrent interview and medical record review for Residents 3, 16, 19, 23 and 27 was conducted with the DON and IP. The DON and IP verified the above findings and stated the pneumococcal immunization was not up to date for Residents 3, 16, 19, and 23. In addition, the DON and IP verified the updated pneumococcal vaccination was not offered to Resident 27 in the facility. The DON and IP verified the MDS was not coded accurately for the above residents. Cross reference to F883 for examples #12, #13, #14, #15 and #16. 47474 8. Medical record review for Resident 15 was initiated on 4/9/24. Resident 15 was admitted to the facility on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 15's Resident Immunization Record Form, (undated), showed Resident 15 declined the pneumonia vaccine on 1/8/16. Further review of Resident 15's medical record showed no documented evidence Resident 15 was educated on the risk and benefits of the pneumonia vaccine, provided a VIS (Vaccine Information Statement) handout from the CDC, signed a consent acknowledging a declination of the pneumonia vaccine. Review of Resident 15's Annual MDS dated [DATE], Section O, showed pneumococcal vaccine was offered and declined. 9. Medical record review for Resident 33 was initiated on 4/9/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Resident Immunization Record Form, (undated), showed Resident 33 received a pneumonia vaccination on 2/10/23. However, the form did not show what type of pneumococcal vaccination was administered to Resident 33. Review of Resident 33's Physician's Telephone Order form showed Resident 33 had a physician's order to receive the Pneumovax 23 vaccine on 2/10/23. Review of Resident 33's Quarterly MDS dated [DATE], Section O, showed a yes response to pneumococcal vaccine was up to date. 10. Medical record review for Resident 18 was initiated on 4/9/24. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 18's Resident Immunization Record Form, (undated), showed Resident 18 received a pneumonia vaccine on 6/10/21. However, the form did not show what type of pneumococcal vaccination was administered to Resident 18. Review of Resident 18's physician Orders List showed Resident 18 had a physician's order to receive the Pneumovax 23 vaccine on 6/10/21. Review of Resident 18's Quarterly MDS dated [DATE], Section O, showed a yes response to pneumococcal vaccine was up to date. 11. Medical record review for Resident 31 was initiated on 4/9/24. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's Resident Immunization Record Form, (undated), showed Resident 31 received PPV on 6/4/21, outside of the facility. However, the form did not indicate what type of pneumonia vaccination was administered. Further review of Resident 31's Immunizations history form showed Resident 31 received the Pneumococcal conjugate PCV 13 on 6/4/21. Review of Resident 31's Quarterly MDS dated [DATE], Section O, showed a yes response to pneumococcal vaccine was up to date. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/9/24 at 1517 hours, a concurrent interview and medical record review was conducted with the IP. The IP verified the above findings for Residents 15, 18, 31, and 33. The IP also verified the MDS Section O showed if the residents were up to date on their pneumococcal vaccine. The IP acknowledged Resident 15's MDS Section O was inaccurately documented since Resident 15 was not offered the pneumococcal vaccine after declining the pneumococcal vaccine on 1/8/16. The IP also stated Residents 18, 31, and 33's MDS Section O were also inaccurately documented and the response to the question should have been marked with a no. On 4/10/24 at 1241 hours, a telephone interview with the MDS Coordinator was conducted. The MDS Coordinator verified the above findings. The MDS Coordinator stated she received the CDC updates for the pneumococcal vaccines from the IP and stated she was not informed of the updated guidelines from January 2022. On 4/10/24 at 1302 hours, an interview with the DON and the Administrator was conducted. The DON and the Administrator acknowledged above findings. Cross reference to F883 for #17, #18, #19, and #20.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview, medical record review, and facility P&P review, the facility failed to provide a summary of the baseline care plan for one of one reviewed resident (Resident 441). This failure had the potential for inappropriate interventions and care for Resident 441. Findings: Review of the facility's P&P titled Care Plans- Baseline revised December 2016 showed the resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information on the details of the comprehensive care plan, as necessary. During the initial tour on 4/2/24 at 0845 hours, Resident 441 stated the SSD spoke to her about the physical therapy for walking and returning home. Resident 441 stated she did not have a discussion of her plan of care or received a copy of the documents for a summary of her baseline care plan. Medical record review was initiated for Resident 441 on 4/3/24. Resident 441 was admitted to the facility on [DATE]. Review of Resident 441's H&P examination dated 3/28/24, showed Resident 441 had the capacity to understand and make decisions. Further review of Resident 441's medical record did not show documented evidence Resident 441 was informed or provided a summary of her baseline care plan. On 4/3/24 at 1020 hours, an interview was conducted with the DSD. The DSD stated the RN completed the care plan within 72 hours of the resident's admission. The DSD further stated if the RN was not able to complete the care plan, the DON would complete the care plan and assessments of the newly admitted residents. The DSD stated the IDT would conduct a care plan meeting with the newly admitted residents to discuss their care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 at 1110 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the care plan should be completed within 24 hours. The DON stated the initial care plans included psychosocial concerns, risk safety, risk for falls, side rails, pain, nutrition, activities of daily living, bowel and bladder elimination, risk for dehydration, rehabilitation services, active diagnoses, and active medications. The DON stated a care plan meeting was completed within 72 hours of a resident's admission. The IDT which included the SSD/Activities Director, RD, DON, and dietary supervisor will meet with the resident to discuss the resident's care and concerns. The DON stated the facility did not provide copies of a summary baseline care plan to the residents unless requested by the resident but the residents were informed of their care. The DON verified there was no documentation to show Resident 441 was provided a copy of a summary baseline care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, and medical record review, the facility failed to develop and implement the comprehensive plan of care to reflect the individual care needs of one of 14 sampled residents (Resident 22). The facility failed to develop a care plan problem to address Resident 22's noncompliance with a physician's order to apply her abduction pillow at all times while in bed. This failure posed the risk of not providing appropriate, consistent, and individualized care to Resident 22. Findings: Medical record review for Resident 22 was initiated on 4/3/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 3/21/24, showed Resident 22 had the capacity to understand and make decisions and had diagnosis for status post repeated surgery for infection open reduction and internal fixation (ORIF, put pieces of a broken bone into place using surgery with screws, plates, sutures, or rods to hold the broken bones together). Review of Resident 22's Physician's Orders for April 2024 showed a physician's order dated 3/19/24, to apply a hip abduction pillow while in bed at all times to Resident 22. Review of Resident 22's General Nurses' Notes dated 4/2/24, showed, Res noted with episodes of removing Abductor pillow. Risk and benefits explained, res. got upset, stated It's my right. Frequent visual checks done to ensure safety and comfort. Review of Resident 22's Comprehensive Plan of Care did not show a care plan problem was developed to address Resident 22's noncompliance with the use of abduction pillow. During the wound treatment observation for Resident 22 on 4/3/24 at 1524 hours, Resident 22's abduction pillow was removed and at the right side of her bed. On 4/3/24 at 1550 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the abduction pillow should not be removed while Resident 22 was in bed if the physician's order was to apply the abduction pillow at all times while Resident 22 was in bed. On 4/4/24 at 0851 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 22's abduction pillow should be in place at all times while in bed per the physician's order. The DON stated Resident 22 had episodes of noncompliance for removing her abduction pillow. The DON verified the above findings. The DON verified there was no care plan problem to address Resident 22's noncompliance for removing the abduction pillow.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide an individualized and ongoing activity program to meet the needs and interests of one of one resident reviewed for activity (Resident 11). The facility failed to provide activities for Resident 11 which met his identified interests. This failure had the potential for Resident 11 to experience feelings of social isolation and frustration. Findings: Review of the facility's P&P titled Activity Program revised June 2018 showed the activity program are designed to meet the interest of and support the physical mental and psychosocial well being of each resident. Further review of the P&P showed the activities offered are based on the comprehensive resident centered assessment and the preferences of each resident. On 4/2/24 at 0942 hours, and 4/3/24 at 0801 and 1308 hours, Resident 11 was observed lying awake in bed staring at the wall. On 4/2/24 at 1024 hours, an interview was conducted with Resident Representative 1. Resident Representative 1 stated she visited Resident 11 almost every day in the evening and had not seen the facility providing activities to Resident 11. On 4/4/24 at 1008 hours, an observation and a concurrent interview was conducted with CNA 2. Resident 11 was observed in bed awake and the television was observed to be turned off. CNA 2 verified the observation. CNA 2 was asked if the facility provided any activities to Resident 11, she stated she had not seen the facility provided activities to Resident 11; however, when the resident's family member came in to visit Resident 11 in the evening, they provided music and turned on the television for Resident 11. Medical record review for Resident 11 was initiated on 4/2/24. Resident 11 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 10/7/23, showed Resident 11 had no capacity to understand and make decisions. Review of Resident 11's MDS dated [DATE], showed Resident 11 had severe cognitive impairment. Review of Resident 1's Activity assessment dated [DATE], showed Resident 11's current activity preference which required 1:1 staff assistance (one resident to one staff) with cards and other games, exercise/sports, reading writing, spiritual religious, and talking conversing. Resident 11 was able to independently participate in listening to music and watching television. Further review of the activity assessment showed Resident 11 required prompts and cues to increase participation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's Care Plan dated 10/5/23, showed a problem addressing little or no involvement in the activities. The interventions included activities department to provide room visit with the resident's activity of interest and to provide sensory stimulation three times a week. The care plan interventions included activities to provide materials to assist with independent activities. Review of Resident 11's Activity Attendance Record for March and April 2024 showed there was no activity provided from 4/1to 4/4/24; and in March 2024, Resident 1 was mostly provided with beauty social, educational/current events, hand massage/manicure, and movie on the television on 3/7, 3/9, 3/11, 3/12, 3/19, 3/21, and 3/25/24. Review of the Activity Attendance Record for March 2024 showed Resident 11 were provided with room visits and mostly provided sensory stimulation and spiritual/religious/hymns on 3/4, 3/5, 3/8, 3/14, 3/15, 3/18, 3/23, and 3/26/24. Further review of the Activity Attendance Record for March 2024 did not show if Resident 11 was provided with any activity on 3/1, 3/2, 3/3, 3/6, 3/10, 3/13, 3/16, 3/17, 3/20, 3/22, 3/24, 3/27, 3/28, 3/29, 3/30, and 3/31/24. On 4/4/24 at 1440 hours, an observation and concurrent interview was conducted with the Activity Director. Resident 11 was observed lying in bed awake and staring at the wall, television was not observed to be on, or any in-room sensory stimulation was observed. The Activity Director verified the observation and above findings. The Activity Director stated Resident 11 required daily activities and the preferred activity should have been provided to Resident 11 as identified in activity assessment and care plan. On 4/4/24 at 1626 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, and medical record review, the facility failed to ensure to provide the necessary services to attain or maintain the highest practicable well-being for three of three reviewed residents (Residents 20, 22, and 36). * The facility failed to ensure Resident 22's abduction pillow and bilateral heel protectors were in place while in bed per the physician's orders. In addition, the facility failed to ensure Resident 22 did not wear the left knee immobilizer while Resident 22 was in bed per the physician's order. The facility failed to ensure Resident 22 had other bowel management medication intervention as needed. * The facility failed to ensure the hospice and facility collaborated in the hospice care for Residents 20 and 36. * The facility failed to ensure a hospice care member participated in Resident 36's Quarterly IDT meeting. Findings: 1.a. Medical record review for Resident 22 was initiated on 4/3/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 3/21/24, showed Resident 22 had the capacity to understand and make decisions and had diagnosis for status post repeated surgery for infection open reduction and internal fixation (ORIF). Review of Resident 22's Physician's Orders for April 2024 showed the following physician's orders: - dated 3/19/24, to apply a hip abduction pillow while in bed at all times to Resident 22. - dated 3/19/24, to apply a knee immobilizer on LLE while ambulating to Resident 22. - dated 3/19/24, to apply the bilateral heel protectors every shift as ordered for skin management to Resident 22. During the wound treatment observation for Resident 22 on 4/3/24 at 1524 hours, Resident 22's abduction pillow was removed and placed at the right side of her bed. Resident 22 was observed wearing a left knee immobilizer while she was in bed. Resident 22 was not observed wearing the bilateral heel protectors. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/24 at 1550 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the abduction pillow should not be removed while Resident 22 was in bed if the physician's order was to apply the abduction pillow at all times while Resident 22 was in bed. LVN 1 stated Resident 22 should not be wearing the left knee immobilizer while Resident 22 was in bed if the physician's order was to apply the left knee immobilizer while ambulating. LVN 1 verified Resident 22 did not have the bilateral heel protectors. On 4/4/24 at 0851 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged the above findings. b. Review of Resident 22's Physician's Orders for April 2024, showed the following physician's orders: - dated 3/19/24, to administer Norco (pain medication) 5/325 mg one tablet by mouth every six hours as needed for severe pain. - dated 3/19/24, to administer Sertraline (an antidepressant medication) 50 mg one tablet by mouth for depression manifested by sad facial expression. - dated 3/20/24, to administer senna (a stool softener medication) 8.6 mg one tablet by mouth twice a day for bowel management. Review of Resident 22's Resident Care Details for March 2023, under the question of bowel management size, did not show Resident 22 had an episode of bowel movement from 3/10 to 3/15/24. Review of Resident 22's MAR for March 2024 did not show Resident 22 was administered any medication for bowel management. On 4/5/24 at 0804 hours, an interview and concurrent medical records review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 22 was on Norco medication as needed and at risk for constipation. RN 1 stated the licensed nurses should notify the physician if Resident 22 did not have an episode of a bowel movement for more than three days and should ask for bowel management medication. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings. 47474 2. Medical record review for Resident 20 was initiated on 4/2/24. Resident 20 was admitted to the facility on [DATE], under Hospice A. Review of Resident 20's H&P examination dated 11/7/23, showed Resident 20 had no capacity to understand and make decisions and goals for comfort care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 0919 hours, a concurrent interview and medical record review was conducted with the IP. Review of Resident 20's care plan showed no documented evidence the hospice care team reviewed or acknowledged Resident 20's care plans. The IP stated the hospice care team should also be updated and informed of the resident's care plans to ensure they were in agreement with Resident 20's plan of care. 3. Medical record review for Resident 36 was initiated on 4/2/24. Resident 36 was admitted to the facility on [DATE], under Hospice B. Review of Resident 36's H&P examination dated 11/7/23, showed Resident 36 had no capacity to understand and make decisions. Review of Resident 36's Quarterly IDT dated 1/23/24, showed no documented evidence the hospice care member participated in the meeting. On 4/4/24 at 0919 hours, a concurrent interview and medical record review with the IP was conducted. The IP verified the care plans for Resident 36 was not signed by the hospice care team and could not show documented evidence the hospice care team were aware of the new or updated care plans for Resident 36. Moreover, the IP verified no documented evidence a hospice care member participated in the Quarterly IDT meeting dated 1/23/24. The IP stated the hospice care team should be part of the IDT meeting and review care plans to ensure the hospice and facility were in agreeance of the resident's plan of care. On 4/4/24 at 1455 hours, an interview with the DON was conducted. The DON verified the hospice staff did not sign the care plans or have documented evidence the care plans were reviewed for Resident 20 or Resident 36. The DON stated by signing the care plans, the hospice care team (Hospices A and B) acknowledged and agreed with the facility's plan of care rendered to the residents. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged above findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of two residents reviewed for the use of indwelling urinary catheter (Residents 20 and 35) were provided with the necessary indwelling urinary catheter care to prevent UTI. The facility failed to ensure Resident 20's indwelling urinary catheter orders followed the CDC's guidelines. These failures had the potential to put Residents 20 and 35 at risk for UTI. Findings: Review of the facility's P&P titled Catheter Care, Urinary revised September 2014 showed the following information should be recorded in the resident's medical record: - The date and time that catheter care was given. - The name and title of the individual(s) giving the catheter care. - All assessment data obtained when giving catheter care. - Character of urine such as color (straw-colored, dark or red), clarity (cloudy, solid particles, or blood), and odor. - Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. - Any problems or complaints made by the resident related to the procedure. - How the resident tolerated the procedure. - If the resident refused the procedure, the reason(s) why and the intervention taken. - The signature and title of the person recording the data. 1. During initial tour of the facility on 4/2/24 at 0844 hours, Resident 35 was observed with an indwelling urinary catheter hanging on the right side of her bed with a blue privacy bag. The indwelling urinary catheter tubing was observed with urine which appeared cloudy and had while particles. Medical record review for Resident 35 was initiated on 4/3/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 5/10/23, showed Resident 35 had the capacity to understand and make decisions. Review of Resident 35's Physician's Orders for April 2024, showed the following physician's orders: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 2/22/24, Foley catheter 18 Fr/10 ml to gravity drainage for wound healing. Change monthly and as needed if removed or blockage. May irrigate the Foley catheter with 100 ml of sterile water as needed if clogged. - dated 3/17/24, may flush the Foley catheter with normal saline 250 ml three times a day as needed. Review of Resident 35's TAR (Treatment Administration Record) for March and April 2024 did not show documentation of the indwelling urinary catheter care. Review of Resident 35's Comprehensive Plan of Care showed a problem care area for the Foley catheter dated 2/22/24, with an intervention for catheter care every shift and as needed. Review of Resident 35's General Nurses Notes from 3/31-4/2/24, did not show documented evidence an indwelling urinary catheter care was provided every shift to the resident. Review of Resident 35's Resident Care Details showed the following: - dated 3/27, 3/29, 3/30, and 4/2/24, an indwelling catheter care was provided at 0700 hours and 2300 hours. - dated 3/28/24, an indwelling catheter care was provided at 0700 hours. On 4/3/24 at 0828 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 verified Resident 35 had an indwelling urinary catheter with yellow and clear urine in the tubing. On 4/3/24 at 1051 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated an indwelling urinary catheter care included peri-care, monitoring the fluid intake and urine output, and urine drainage every shift or as needed. LVN 1 stated the CNAs reported the urine output to the charge nurse at the end of the shift and the LNs (licensed nurses) recorded the amount of urine output. LVN 1 stated Resident 35's indwelling urinary catheter was used for wound management. LVN 1 verified there was no order for an indwelling urinary catheter care for Resident 35. LVN 1 further verified Resident 35's MAR for March and April did not show documentation an indwelling urinary catheter care was provided every shift for Resident 35. On 4/3/24 at 1150 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated there should be a standing order for an indwelling urinary catheter care every shift or as needed to show the documentation indwelling urinary catheter care was provided every shift and as needed. 47474 2. Review of the CDC's Infection Control - Catheter-Associated Urinary Tract Infections (CAUTI) 2009 showed Proper Techniques for Urinary Catheter Maintenance included changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Catheter Care, Urinary revised on 9/2014 showed the purpose of the procedure is to prevent catheter-associated urinary tract infections. The P&P showed changing the indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Medical record review for Resident 20 was initiated on 4/2/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's medical record showed a physician's order dated 11/7/23, for Resident 20 to have an indwelling urinary catheter with a size 20 Fr/10 ml and to change the Foley catheter as needed if removed or blocked, and may irrigate the Foley catheter with 80 ml sterile water as needed if clogged. Further review of Resident 20's medical record showed a physician's order dated 11/7/23, to change the Foley catheter bag every week on Sunday. Review of Resident 20's March 2024 eTAR showed the Foley catheter bag was changed weekly on Sundays for the following dates: - 3/3/24 - 3/10/24 - 3/17/24 - 3/24/24 - 3/31/24 On 4/4/24 at 0943 hours, a concurrent interview and medial record review was conducted with the IP. The IP verified Resident 20 had routine orders to change the Foley catheter bag weekly on Sunday. The IP denied Resident 20 was assigned to a urologist and was following the physician's orders to change the Foley catheter bag weekly on Sunday. The IP acknowledged the weekly Foley catheter bag changes increased the risk for infection. On 4/4/24 at 1109 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 20 had an indwelling urinary catheter size 20 Fr/10 ml. The DON stated the indwelling catheter bags and indwelling catheters should be changed out as needed to help reduce the risk for infection.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, and medical record review, the facility failed to ensure the nutrition needs were met for one of two residents reviewed for nutrition (Resident 32). * The facility failed to ensure Resident 32 was offered alternative when Resident 32 consumed less than 50% of his meal tray. This failure had the potential to compromise Resident 32's nutritional status. Findings. On 4/2/24 at 0802 hours, an interview was conducted with Resident 32. Resident 32 stated he had been losing weight; however, he thought the current weight was his ideal weight. Medical record review for the Resident 32 was initiated on 4/2/24. Resident 32 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 32's Vital Signs Grid dated 4/5/24, showed following weights: - 3/4/24, 174 lbs (pounds); - 2/26/24, 174 lbs; - 2/19/24, 168 lbs; - 2/12/24, 168 lbs; - 2/5/24, 168 lbs; and, - 1/5/24, 180 lbs. Review of Resident 32's MDS dated [DATE], showed Resident 32 was cognitively intact. Review of Resident 32's Physician Order dated 2/29/24, showed a physician's order for the resident's diet to liberalize diet to regular with large protein portion. On 4/2/24 at 1233 hours during the dinning observation, Resident 32 was observed eating his lunch in his room. The meal tray was observed with white bread with herbs, zesty lasagna, green beans, one banana, 8 oz (eight ounces) of boost, a cup of chicken noodle soup, a cookie, a cup of grape juice, and a cup of water. Resident 32 was observed eating one cup of chicken noodle soup, 8 oz of boost, a bite of cookie, and half banana. Resident 32 was not observed eating the main portion of the meal bread with herbs, zesty lasagna, green beans, a cup of grape juice and water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 1255 hours, an observation and concurrent interview was conducted with the IP. The IP was observed asking Resident 32 if he was done with his meal, Resident 32 stated yes. The IP then was observed taking out the tray of Resident 32's meal. The IP verified Resident 32 ate less than 50% of his meal tray. The IP was not observed offering an alternative meal to Resident 32. On 4/2/24 at 1259 hours, a follow-up interview was conducted with the IP. The IP verified Resident 32 ate less than 50% of his meal tray and she did not offer alternatives to the Resident 32. The IP further stated she should have offered the alternatives to the Resident 32 when he ate less 50% of his meal tray. The IP then was observed going back to Resident 32's room and offering alternative meal to Resident 32. On 4/4/24 at 0808 hours, an interview was conducted with the DON. The DON was informed of the above findings. The DON stated when taking the meal tray out and if the staff noticed the resident eating less than 50% of their meal tray, then the staff should offer an alternatives to the resident to maintain their nutritional status. The DON stated the IP should have offered the alternative meal to the Resident 32 when he ate less than 50% of his tray. On 4/5/24 at 1440 hours, a telephone interview was conducted with the RD. The RD was informed of the above findings and stated the staff in the facility should offer alternative meal when the resident ate less than 50% of any specific meal. Cross reference to F842 example #2

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure three of four sampled residents with GT (Residents 2, 9, and 36) were provided care as evidence by: * The facility failed to ensure CNA 6 worked within their scope of practice as shown on the facility's document titled Patient Care Assistant - CNA Job Description. * The facility failed to ensure Residents 2, 9, and 36's GT tubing were properly labeled. These failures posed the risk for negative outcomes for the residents with GT. Findings: Review of the facility's P&P titled Enteral Feedings - Safety Precautions revised 12/2011 showed all personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. The facility will remain current in and follow accepted best practices in enteral nutrition. The P&P further showed administration set changes include: a. Change administration sets for open-system enteral feedings at least every 24 hours b. Change administration sets for closed-system enteral feedings according to manufacture's instructions. Review of the facility's document titled Patient Care Assistant - CNA Job Description, undated, showed the Nursing Assistant assists the resident in performing activities of daily living, provides a clean and safe living environment, gathers data on the resident's physical and emotional state, and reports observations to the nurse in charge. The facility document further showed the standard of performance for CNA include performing routine patient care in accordance with Company and Center policies and nursing procedures. 1. Medical record review for Resident 9 was initiated on 4/2/24. Resident 9 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 9's medical record showed a physician's order dated 5/20/23, showed the resident had a GT. Further review of Resident 9's medical record showed the resident was on GT feeding formula, Jevity 1. 5 at 40 ml/hr via GT for 20 hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 0842 hours, a concurrent observation and interview was conducted with CNA 6. CNA 6 was observed turning off Resident 9's GT feeding machine. CNA 6 verified the finding and stated he turned off the GT feeding machine so that he could clean the resident. When asked if turning off GT feeding machines was within a CNA's scope of practice, CNA 6 stated no; however, he sometimes turned the GT feeding machine on and off to help the charge nurse when they were not available to turn on or off the GT feeding machine. On 4/4/24 at 0918 hours, an interview with the DSD was conducted. The DSD verified the CNA could not turn on or off the GT feeding machine and stated it was not within their scope of practice. The DSD stated the CNA needed to notify the charge nurses since the charge nurses monitored the residents on GT feeding to ensure they were receiving the complete dose of their feeding. On 4/4/24 at 1455 hours, an interview with the DON was conducted. The DON stated it was not within the CNA's scope of practice to turn on or off the GT feeding machine. The DON further stated only the license nurses were able to turn on or off the GT feeding machine. 2.a. Medical record review for Resident 2 was initiated on 4/2/24. Resident 2 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 2's medical record showed a physician's order dated 12/5/23, showed the resident had a GT. Further review of Resident 2's medical record showed the resident was on GT feeding formula, Fibersource HN 1.2 at 40 ml/hr via GT for 20 hours. On 4/2/24 at 0913 hours, an initial tour of the facility was conducted. Resident 2's GT tubing was observed with no label showing when it was changed. b. Medical record review for Resident 9 was initiated on 4/2/24. Resident 9 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 9's medical record showed a physician's order dated 5/20/23, showed the resident had a GT. Further review of Resident 9's medical record showed the resident was on GT feeding formula, Jevity 1. 5 at 40 ml/hr via GT for 20 hours. On 4/2/24 at 0918 hours, an initial tour of the facility was conducted. Resident 9's GT tubing was observed with no label showing when it was changed. c. Medical record review for Resident 36 was initiated on 4/2/24. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's medical record showed a physician's order dated 9/18/23, showed the resident had a GT. Further review of Resident 36's medical record showed the resident was on GT feeding formula, Jevity 1.5 at 50 ml/hr via GT for 20 hours. On 4/2/24 0936 hours, an initial tour of the facility was conducted. Resident 36's GT tubing was observed with no label showing when it was changed. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 0950 hours, a concurrent observation and interview was conducted with LVN 2. LVN 2 verified Residents 2, 9, and 36 had GT. LVN 2 further verified Residents 2, 9, and 36's GT tubing were not labeled. LVN 2 stated GT tubing should be labeled to ensure the tubing was changed daily. On 4/4/24 at 1455 hours, an interview with the DON was conducted. The DON stated her expectation for the charge nurses caring for the residents on GT was to change out the GT feeding, syringe, and tubing every 24 hours; and label and date the feeding, syringe, and tubing. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care services for two of three residents reviewed for respiratory care (Residents 2 and 17). * The facility failed to provide oxygen therapy as per the physician's order for Resident 17. * The facility failed to ensure Resident 2's suction machine canister was discarded after use and failed to ensure an oxygen bag was available and suction machine bag was dated. These failure posed the risk for residents' safety and respiratory related complications including infection. Findings: Review of the facility's P&P titled Oxygen Administration revised October 2010 showed to verify that there was a physician order for the procedure and to review the physician's orders or facility protocol for oxygen administration. Medical record review for Resident 17 was initiated on 4/2/24. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/2/24 at 0910 hours, an observation, interview, and concurrent medical record review for Resident 17 was conducted with LVN 2. Resident 17 was observed lying in bed and receiving oxygen at 3 LPM (liters per minute)via nasal cannula. LVN 2 verified the observation and acknowledged Resident 17 was receiving oxygen at 3 LPM. LVN 2 acknowledged Resident 17 was receiving oxygen at 3 LPM instead of 2 LPM as ordered by the physician. Review of the Resident 17's Physician Order List dated 1/19/24, showed an order to administer oxygen at 2 LPM via nasal cannula continuously. However, during the above observation, Resident 17 was on oxygen at 3 LPM via nasal canula. On 4/4/24 at 0808 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings. 47474 2. Review of the facility's P&P titled Oxygen Administration revised on 10/2010 showed to discard used supplies into designated containers. Medical record review for Resident 2 was initiated on 4/2/24. Resident 2 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. Review of Resident 2's medical record showed a physician's order dated 12/5/23, to administer oxygen at 2 LPM continuously via nasal cannula and may suction as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 0913 hours, an initial observation of the facility was conducted. Resident 2 was observed with 2 LPM oxygen via nasal cannula with no oxygen bag noted. Further observation showed a suction machine canister with white liquid secretion and suction machine bag not dated. On 4/2/24 at 0931 hours, a concurrent observation and interview was conducted with LVN 2. LVN 2 stated Resident 2 was on continuous oxygen at 2 LPM via nasal cannula. LVN 2 verified Resident 2 did not have an oxygen bag to store the nasal cannula if Resident 2 went to an appointment using a portable oxygen tank. LVN 2 further verified Resident 2's suction machine bag was not dated and the suction machine canister was observed with white liquid secretions. LVN 2 stated Resident 2 should have an oxygen bag and a suction machine bag properly dated and labeled to ensure respiratory materials were changed out on a weekly basis. LNV 2 also stated the suction machine canister should have been replaced once it was used to ensure infection control was maintained. On 4/4/24 at 1455 hours, an interview with the DON was conducted. The DON stated oxygen bags should be labeled with a date and changed out weekly on Fridays. The DON stated the suction machine canisters were discarded after every use to prevent bacterial from growing and for infection control. On 4/5/24 at 1550 hours, an interview was conducted with the DON. The DON acknowledged above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the ongoing assessment before, during, and after dialysis treatments for one of one resident reviewed for dialysis services (Resident 10) was conducted as evidenced by: * Resident 10's dialysis communication forms dated 4/2 and 4/4/24, were incomplete. This failure had the potential of not identifying negative outcomes for the dialysis resident (Resident 10). Findings: Review of the facility's P&P titled Hemodialysis Access Care revised on 9/2010 showed documentation included: 1. Location of the catheter 2. Condition of the dressing (interventions if needed) 3. If dialysis was done during the shift 4. Any part of the report from dialysis nurse post-dialysis being given 5. Observations post-dialysis Medical record review for Resident 10 was initiated on 4/5/24. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's physician's order dated 2/1/24, showed Resident 10 had dialysis on Tuesdays, Thursdays, and Saturdays. Review of Resident 10's dialysis care plan dated 2/2/24, showed an intervention to check the resident's shunt for bruit and thrill on the LUA QS (left upper arm every shift). Further review of Resident 10's medical record showed the dialysis communication forms dated 4/2 and 4/4/24, were incomplete. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/24 at 1119 hours, a concurrent interview and medical record review with the IP was conducted. The IP stated Resident 10 had an AV shunt to the left upper arm. The IP verified Resident 10's dialysis communication form dated 4/2/24, under the section titled Dialysis Unit on the Access Site Assessment was left blank. The IP further verified Resident 10's dialysis communication form dated 4/4/24, under the section titled Post Dialysis Assessment #2 showed the assessments of the bruit and thrill were blank. The IP stated the Dialysis Unit completed the section titled Dialysis Unit while the resident was at the dialysis center and should have answered the Access Site Assessment question. The IP stated the nurses would contact the dialysis center to complete. The IP further stated the nurses assessed the dialysis residents upon return from the dialysis center every four hours for a total of three assessments. The IP verified the nurses did not show documented evidence the bruit and thrill were assessed on the second assessment post dialysis dated on 4/4/24. The IP stated assessing the bruit and thrill were important to ensure the resident's dialysis site was still working and accessible. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged the above findings.

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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** 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services to meet the needs of residents. The emergency kit for the facility's oral medications was not replaced in a timely manner. This failure had the potential for to contribute to a decreased availability of medications in an emergency. Findings. Review of the facility's P&P titled Availability and Use of Emergency Medication Kits revised January 2020 showed the facility must notify pharmacy when an emergency kit was opened and needs replacement. Further review of the P&P showed the pharmacy will then replace the open kit on the next working day. On 4/3/24 at 1518 hours, during the inspection of Medication Storage room [ROOM NUMBER] with the IP, the emergency kit for the oral medications was observed to be locked with a white zip tie. The IP stated the emergency kit locked with white zip tie was once opened and meant to alert staff it needed to be replace. The Emergency kit dose slip inside the emergency kit showed the medication levofloxacin 250 mg (antibiotic) was removed on 3/30/24. The IP verified the observation and stated the emergency kit was opened since 3/30/24. The IP stated the staff who opened the emergency kit should have notified the pharmacy immediately after opening and the pharmacy should replace the emergency kit within 72 hours. On 4/3/24 at 1615 hours, a telephone interview was conducted with the Pharmacy Technician. The Pharmacy Technician stated the staff in the facility should inform the pharmacy immediately after opening the emergency kit and the pharmacy to replace the emergency kit the next day. The Pharmacy Technician verified the pharmacy did not receive the notification for the oral emergency kit to be replaced in the facility when it was opened on 3/30/24, he stated he received the call from the facility for the oral emergency kit replacement on 4/3/24 around 1500 hours (four days after opening the emergency kit). On 4/4/24 at 0808 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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** 46807 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the Pharmacy Consultant's recommendations were acted upon for two of five residents reviewed for unnecessary medications (Residents 22 and 32). * The facility failed to ensure the Pharmacy Consultant's recommendation to provide duration of the therapy for enoxaparin (its brand name, Lovenox, an anticoagulant used to decrease the clotting ability of the blood) for Resident 22 was acted upon. This failure had the potential to put Resident 22 at risk for adverse consequences related to the medication. * The failed to ensure the physician provided a rational when no action was taken for the Pharmacy Consultant's recommendation if clinically feasible to provide a duration of therapy for Lovenox for Resident 32. These failures had the potential to put Residents 22 and 32 at risk for adverse consequences related to the medication. Findings: 1. Medical record review for Resident 22 was initiated on 4/3/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 3/21/24, showed Resident 22 had the capacity to understand and make decisions. Review of Resident 22's Physician's Orders for April 2024 showed a physician's order dated 3/19/24, to administer enoxaparin (Lovenox) 40 mg/0.4 ml syringe injection subcutaneously (injections given into the fat under the skin) daily for deep vein thrombosis (DVT, a condition that occurs when a blood clot forms in a deep vein) prophylaxis. Review of Resident 22's MAR for April 2024 showed enoxaparin (Lovenox) was administered daily at 0900 hours. Review of Resident 22's Consultant Pharmacist's Medication Regimen Review for the month of February 2024 showed a recommendation dated 2/13/24, for Resident 22 if clinically feasible to provide a duration of therapy for Lovenox. Further review of Resident 22's medical record did not show documented evidence Resident 22's physician was notified or if the Pharmacy Consultant's recommendation for Lovenox was acted upon. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/24 at 0921 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated she did not find documentation the Pharmacy Consultant's recommendation for Lovenox was followed up and if Resident 22's physician was notified by the recommendation and if he/she agreed or disagreed with the Pharmacy Consultant's recommendation to provided duration of therapy for Lovenox. 44175 2. Review of the facility's P&P titled Medication Regimen Review revised May 2019 showed the following: - The consultant pharmacist preforms a medication regimen review (MRR) for every resident in the facility receiving medication upon admission and at least monthly thereafter, or more frequently if indicated. - The irregularity referred to the use of medication that was inconsistent with accepted pharmaceutical services standard of practice was not supported by medical evidence and or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and are in the presence of adverse consequences. - The attending physician to document in the medical record that irregularity have been reviewed and what (if any) action was taken to address it. - Consultant pharmacist provides the director of nursing services and medical director with a written signed and dated copy of all medication regimen report. - Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. Medical record review for the Resident 32 was initiated on 4/2/24. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's Order Summary Report showed a physician's order dated 2/1/24, to administer Lovenox 40 mg per 0.4 ml, 0.4 ml subcutaneously (given into the subcutaneous fat under the skin) every day. Review of the Consultant Pharmacist's Medication Regimen Review for Resident 32 dated 3/1/24, showed if clinically feasible, to provide a duration of therapy for the prescribed lovenox medication for Resident 32. The document further showed a handwritten note continue as per MD. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/5/24 at 0819 hours, an interview and concurrent medical record review for Resident 32 was conducted with the DON. When the DON was asked how the facility informed the prescribing physician about the pharmacy consultant's recommendations, the DON stated she faxed the prescribing physician to inform of the pharmacy consultant's recommendation. The DON stated when she received the response back, she would follow up, then she would mark the medication regimen review form to indicate that it was done or verified. When asked about the pharmacy consultation's recommendation to provide a duration of therapy for the prescribed lovenox medication for Resident 32, the DON verified the handwritten note continue as per MD. The DON stated for Resident 32, she received response back from the resident's physician stating to continue same order on the same day of the medication regimen review date which was 3/1/24. The DON was asked if the physician provided the documented rational for not acting upon the pharmacy consultant's recommendations and continued the medication order as it was; the DON stated no, the MD did not provide the rational.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the residents were free from the unnecessary psychotropic medications (any drug that affects brain activity associated with mental processes and behavior) for two of two residents reviewed for antipsychotic medications (Residents 20 and 35). * Resident 35 had an order for olanzapine (its brand name, Zyprexa, an antipsychotic medication). The facility failed to ensure Resident 35 was assessed for Abnormal Involuntary Scale (AIMS, a rating scale that was designed in the 1970s to measure involuntary movements known as tardive dyskinesia (TD) for the use of olanzapine (Zyrexa). * Resident 20 had an order for bupropion (Wellbutrin) (antidepressant medication) and quetiapine (Seroquel) (antipsychotic medication). The facility failed to ensure Resident 20 was assessed for abnormal involuntary movement using the AIMS (The Abnormal Involuntary Movement Scale) test for the use of bupropion and quetiapine medications. These failures had the potential for the residents to have adverse complications from the medications and the potential of not providing the correct data to the prescriber in order to adjust the dose of the psychotropic medications for the residents. Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 7/2022 showed the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Review of the facility's P&P titled Antipsychotic Medication Use revised July 2022 showed the nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physicians: d. Neurologic: akathisia, dystonia, extrapyramidal effects, akinesia, or tardive dyskinesia, stroke, or TIA. 1. Medical record review for Resident 35 was initiated on 4/3/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 5/10/23, showed Resident 35 had the capacity to understand and make decisions. Review of Resident 35's Physician's Orders for April 2024 showed the following physician's orders: - dated 2/16/24, to administer Resident 35 olanzapine 5 mg tablet, one tablet by mouth at bedtime for schizoaffective disorder and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 2/16/24, to document episodes of schizoaffective disorder as manifested by constantly yelling or calling for help and calling different people like her children and parents every shift for olanzapine use. - dated 2/26/24, to monitor for antipsychotic drug side effects every shift for the use of olanzapine. Review of Resident 35's MAR for the month of April 2024 showed Resident 35 was administered olanzapine 5 mg at 2100 hours daily. Further review of Resident 35's medical record did not show documented evidence the AIMS assessment was completed for the use of antipsychotic medication such as olanzapine. On 4/5/24 at 0752 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated AIMS was an assessment completed if there were side-effects of hypotension or Parkinsonism (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). RN 1 verified there was no documentation the AIMS assessment was completed for Resident 35's use of olanzapine medication. On 4/5/24 at 0838 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The DON stated the facility did not have a form to assess for AIMS. The DON stated moving forward, the facility would implement the assessment of AIMS in the residents with the use of antipsychotic medications. 47474 2. Medical record review for Resident 20 was initiated on 4/2/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 11/7/23, showed Resident 20 had no capacity to understand and make decisions. Review of Resident 20's Physician's Orders for April 2024 showed the following physician's orders: - To administer quetiapine fumarate 25 mg one tablet by mouth twice daily for mood disorder M/B (manifested by)hallucinations dated 11/8/23. - To administer bupropion HCL SR 150 mg one tablet by mouth twice daily for depression M/B verbalization of feeling sad dated 11/7/23. - To monitor episodes of verbalization of hallucinations every shift dated 11/8/23. - To monitor episodes of verbalization of feeling sad every shift dated 11/7/23. Further review of Resident 20's medical record showed no documented evidence the AIMS assessment was completed for Resident 20's use of quetiapine and bupropion medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1445 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 verified the above findings and stated the facility did not perform the AIMS assessment. LVN 2 further stated the AIMS assessment was to assess for the side effects of the antipsychotic medications. On 4/4/24 at 1455 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 20 was receiving quetiapine and bupropion medications. The DON further verified the facility did not perform the AIMS assessment for Resident 20 and any of the residents with antipsychotic medications. The DON stated the facility would implement the AIMS assessment moving forward.

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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. 44175 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were not left unattended on the medication cart for one of two residents reviewed for medication administration (Resident 3). This failure had the potential for medication diversion. Findings: Review of the facility's P&P titled Storage of Medication revised April 2019 showed the drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Further review of the P&P showed to not leave medications unattended on the medication cart. On 4/3/24 at 0845 hours, a medication pass observation was conducted with LVN 2. LVN 2 was observed preparing the following medications for Resident 3: - Amantadine (medication to treat Parkinson's disease) 50 mg/ml 5 ml; - Decousate sodium (stool softer) two tablets;. - Rivastigiminie 9.5 mg (medicine to treat dementia) transdermal system (a technique that provides drug absorption via the skin); - Oxybutynin 50 mg (a medicine used to treat symptoms of an overactive bladder) one tablet; - Carbidopa levodepa (medication to treat Parkinson disease) 10-100 mg one tablet; - Vitamin D3 25 mcg two tablets; - Vitamin C- 500 mg two tablets; - Multivitamin with minerals one tablet; and - Potassium Chloride 20 meq/15 ml, mixed with 120 ml of water. LVN 2 crushed the tablets separately, mixed each crushed medications with 5 mls of water in a medication cup and put it in a tray. LVN 2 then left the tray with prepared medications unattended on the medication cart to look for overbed table. LVN 2's medication cart was parked in the hallway where the staff, visitors, and residents passed through. LVN 2 went back to the medication cart and took the tray with the medications to the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 0935 hours, an interview was conducted with LVN 2. When asked about the medications left on top of the medication cart, LVN 2 acknowledged her actions and stated she should not have left the medications unattended. On 4/4/24 at 0808 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the puree recipes and renal and CCHO menus were followed for three residents (Residents 11, 18, and 35) with puree diet, two of four residents (Residents 11 and 18) with a puree renal diet, and 10 of 32 residents (Residents 5, 10, 11, 13, 16, 17, 18, 28, 29, and 35) on CCHO diet as evidenced by: * The facility failed to ensure the puree recipes were followed. * The facility failed to ensure two residents (Residents 11 and 18) on a renal pureed diet did not receive roasted red potatoes. * The facility failed to ensure the residents with a CCHO diet (Residents 5, 10, 11, 13, 16, 17, 18, 28, 29, and 35)received plain ice cream as shown on the Spring Cycle Menu Week 1 dated for 4/3/24. These findings had the potential for the residents on special diets to not receive the adequate nutritional and caloric intake as recommended on the recipes and menus. Findings: 1. Review of the facility's P&P titled Standardized Recipes revised 4/2007 showed standardized recipes shall be developed and used in the preparation of foods. The P&P further showed only tested , standardized recipes will be used to prepare food and the Food Services Manager will maintain the recipe file and make it available to Food Services staff as necessary. Review of the undated Healthcare menus Direct, L.L.C.'s Recipe: Pureed Meats, showed step number two was to puree on low speed to a paste consistency before adding any liquid. The recipe also showed meat per recipe for servings for six, 12, and 24. a. Review of the Spring Cycle Menu Week 1 dated 4/3/24, showed the Regular menu included roast turkey with Bernaise sauce, herb roasted red potatoes, rosemary cauliflower and peas, parsley sprig, fresh green salad, dressing, sherbet, and milk. Review of the facility's Physician Orders List dated 4/2/24, showed Residents 11, 18, and 35 were on a pureed diet. On 4/3/24 at 1102 hours, a concurrent observation and interview was conducted with the DSS. During the puree procedure observation, the DSS stated he was preparing the puree foods for four residents on pureed diets and was following the Recipe: Pureed Meats for six servings. The DSS was observed adding 300 ml turkey broth into a blender and four three-ounce turkey slices prior to blending together. Review of the Recipe: Pureed Meats showed for six servings required six slices of meat. The recipe further showed to puree meat on low speed to a paste consistency before adding any liquids. The DSS verified the above findings. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1317 hours, an interview with the RD was conducted. The RD stated the recipe for pureed meat for a six servings and directions were not followed. The RD further stated she expected the DSS to follow the recipe. b. On 4/3/24 at 1102 hours, a concurrent observation and interview was conducted with the DSS. During the puree food preparation observation, the DSS stated he was preparing the pureed roasted red potatoes. The DSS was observed using the Recipe: Pureed Vegetables instead of the Recipe: Pureed Starch (Rice, Pasta, Potatoes). The DSS verified the findings and stated he used the recipe for pureed vegetables for the red potatoes. On 4/4/24 at 1317 hours, an interview with the RD was conducted. The RD stated the roasted red potatoes should follow under pureed starch. The RD stated the DSS should have followed the recipe for pureed starch instead of pureed vegetables when making the pureed roasted red potatoes. 2. Review of the facility's P&P titled Menus revised 10/2017 showed menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). The P&P further showed menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal. Review of the Spring Cycle Menu Week 1 dated 4/3/24, showed the renal diet should receive brown rice with margarine and wheat bread. Review of the Recipe: Herb Roasted Red Potatoes for Week 1 Wednesday showed for renal diet, do not give. On 4/3/24 at 1255 hours, a concurrent observation and interview was conducted with the DSS. During the tray line observation, the DSS stated two of four residents had pureed renal diet orders. The DSS was observed plating pureed roasted red potatoes for Residents 11 and 18 on pureed renal diet. The DSS verified the menu for renal diet showed brown rice with margarine and wheat bread. The DSS further verified Residents 11 and 18 did not receive brown rice with margarine and wheat bread on their meal tray. The DSS stated the facility did not have brown rice and substituted with white rice instead; however, they should have followed the recipe. On 4/4/24 at 1317 hours, an interview with the RD was conducted. The RD stated the potatoes had higher potassium content. The RD stated the spreadsheet for renal diet should have been followed and Residents 11 and 18 should have received brown rice and wheat bread as shown. 3. Review of the Spring Cycle Menu Week 1 dated 4/3/24, showed the regular CCHO menu included roast turkey with Bernaise sauce, herb roasted red potatoes, rosemary cauliflower and peas, parsley sprig, fresh green salad, dressing, plain ice cream, and milk. Review of the facility's Physician Orders List dated 4/2/24, showed Residents 5, 10, 11, 13, 16, 17, 18, 28, 29, and 35 had the physician's orders for CCHO diets. On 4/3/24 at 1102 hours, during the trayline observation, the Dietary Aide verified she served all of the residents with CCHO diets with sherbert, instead of the plain ice cream listed on the Spring Cycle Menu Week 1. The Dietary Aide stated she should have followed the menu. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1317 hours, an interview with the RD was conducted. The RD stated the DSS should have followed the menu for CCHO diets. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged all of the above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the food test tray was prepared in an appetizing temperature as evidenced by: * Test tray temperatures were below the recommended temperature for hot meats, vegetables, and potatoes. * Three of 38 residents (Residents 12, 26, and 32) had complained the food was cold These failures posed the risk for not providing palatable and appetizing food for the residents receiving a meal tray from the kitchen. Findings: Review of the facility's P&P titled Food Preparation and Service dated 4/2019 showed fresh, frozen, or canned fruits and vegetables are cooked to a holding temperature of 135 degrees Fahrenheit. The P&P showed the danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit and the longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit. 1. Review of the Spring Cycle Menu Week 1 dated for 4/3/24, showed the regular menu included roast turkey with Bernaise sauce, herb roasted red potatoes, rosemary cauliflower and peas, parsley sprig, fresh green salad, dressing, sherbet, and milk. On 4/3/24 at 1358 hours, a concurrent interview and test tray of the regular menu was conducted with the DSS, CNA 5, and four surveyors were present. The DSS checked and verified the following temperatures: * Roast Turkey with Bernaise sauce - 102 degrees Fahrenheit * [NAME] cauliflower and peas - 102 degrees Fahrenheit * Herb roasted red potatoes - 103 degrees Fahrenheit * Coffee - 136 degrees Fahrenheit * Sherbet - 14 degrees Fahrenheit The DSS and CNA 5 verified the temperature of the turkey, cauliflower and peas, and herb roasted red potatoes were not hot. (continued on next page)

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Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 1317 hours, an interview with the RD was conducted. The RD stated holding temperatures for hot foods including meats, vegetables, and potatoes should be over 140 degrees Fahrenheit. The RD verified the test tray temperatures of 102 and 103 degrees Fahrenheit was below the recommended temperatures for a hot meal tray. The RD stated residents may not like the food if it's cold and not palatable. Furthermore, the RD stated potential weight loss could occur if the residents do not eat, which can lead to potential weight loss. 2. On 4/2/24 at 0802 hours, an interview with Resident 32 was conducted. Resident 32 stated he received a french fries that was still frozen inside. On 4/2/24 at 0836 hours, an interview with Resident 12 was conducted. Resident 12 stated with concerns with the food temperature and variety. On 4/2/24 at 1040 hours, an interview with Resident 26 was conducted. Resident 26 stated with concerns with the food being cold when the meal trays were delivered late. On 4/4/24 at 1317 hours, an interview with the RD was conducted. The RD acknowledged three of 38 residents had complaints of their food being cold. The RD stated the hot foods should be kept hot and cold foods kept cold.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen. * The facility failed to ensure the cutting boards and kitchen equipment were in sanitary conditions * The facility failed to ensure the food items were discarded on or before the best by date * The facility failed to ensure the temperature of the food items were checked prior to preparing or distributing to residents * The facility failed to ensure the staff's personal belonging was not stored in the kitchen's clean utility room * The facility failed to ensure the kitchen staff maintained proper hand hygiene * The facility failed to ensure the staff covered food during transportation through the outdoor dry storage room and back inside facility * The facility failed to ensure Resident 4 received the correct diet texture as ordered These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food prepared in the kitchen Findings: Review of the facility census on [DATE] showed there were 38 residents at the facility. The facility document titled Residents on GT Feeding provided on [DATE], showed the facility had six residents on G-tube feeding, resulting in the kitchen providing the diets to 32 residents in the facility. 1. According to the USDA Food Code 2022 ,d+[DATE].12, Cutting Surfaces, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. On [DATE] at 0805 hours, a concurrent observation and interview was conducted with the DSS. One green, one yellow, one brown, one blue, and one red cutting board were observed heavily marred with dark discoloration knife marks. The DSS verified the findings and stated he would replace the set of the cutting boards. 2. According to the USDA Food Code 2022, Section ,d+[DATE].11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On [DATE] at 0805 hours, a concurrent observation and interview was conducted with the DSS. The following was observed and verified by the DSS: * One medium-sized frying pan was observed heavily married on the inside surface * One slotted spoon was noted with a melted handle * One ice cream scooper noted with dried brown food particle * One lime squeezer noted with dried brown food particle The DSS stated the kitchen equipment should be thoroughly cleaned and maintained. 3. On [DATE] at 0745 hours, a concurrent observation and interview was conducted with the DSS. Three honeydew with the best by date of [DATE], and one orange juice pitcher dated [DATE], were observed in Refrigerator 1. The DSS verified the findings and stated the food items should be discarded by the best by date to limit the growth of bacteria. On [DATE] at 1317 hours, the above findings were verified with the RD. The RD stated the expired food items should not be served to the residents and should be discarded on or prior to the best by date. 4. Review of the facility's P&P titled Food Preparation and Service dated ,d+[DATE] showed the danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. According to the USDA Food Code 2022, one of the epidemiological outbreak risk factors related to employee behaviors and preparation practices in retail and food service establishments as contributing to food borne illness include the improper holding temperatures. On [DATE] at 1255 hours, a concurrent observation and interview was conducted with the DSS during the tray line observation. During the observation, the temperature was not checked for the shredded cheddar cheese prior to preparing two cheese quesadillas. Furthermore, the temperature check was not observed for the fresh green salad placed on the food trays stored in Food Cart 1. The DSS verified the temperature of the shredded cheddar cheese was not checked. The temperature of the shredded cheddar cheese read 37 degree Fahrenheit. The DSS also verified the temperature of the fresh green salad was not checked prior to placing on the food trays. The temperature reading for the salad was verified by the DSS with a temperature of 45 degrees Fahrenheit. The DSS stated the temperature of the salad should be below 41 degrees Fahrenheit and stated the facility could not serve the fresh green salad since the temperature was within the danger zone. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1317 hours, an interview with the RD was conducted. The RD stated the hot foods should be kept hot and cold foods kept cold to ensure the foods were outside the danger zone and prevent the growth of bacteria. 5. On [DATE] at 0805 hours, a concurrent observation and interview was conducted with the DSS. One pair of Croc clogs (one type of shoes that is produced by Crocs) was observed in the kitchen's clean utility room. The DSS stated the utility room stored supply items including napkins, plastic utensils, zip bags, and lids. The DSS further stated the personal belongings should not be kept in the kitchen due to potential cross contamination and infection control. On [DATE] at 1317 hours, an interview with the RD was conducted. The RD stated the Croc clogs should not be kept in the kitchen utility room and stated it could bring in dirt from outside. 6. According to the USDA Food Code 2022 ,d+[DATE].14, When to Wash, showed food employees shall clean their hands and exposed portions of their arms after engaging in other activities that contaminate the hands. In addition, according to the USDA Food Code 2022 ,d+[DATE].11, Clean Condition, the hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the USDA Code. On [DATE] at 1102 hours, a concurrent observation and interview was conducted with the DSS. The DSS was observed sanitizing the preparation table with gloves and cleaning towel and then retrieved one stick of margarine from Refrigerator 1 to the stove without performing proper hand hygiene. The DSS verified the findings. On [DATE] at 1317 hours, an interview was conducted with the RD. The RD stated hand hygiene needs to be performed between sanitizing preparation table and handling of the food. The RD further stated hand hygiene was essential to help prevent cross contamination from cleaning the supply and food. 7. On [DATE] at 1255 hours, a concurrent observation and interview was conducted with the DSS. The meal ticket for Resident 4 showed a regular NAS (no added salt) diet; however, the plate on the tray showed the resident had mechanical soft turkey. The DSS verified the findings and redid a regular plate for Resident 4. On [DATE] at 1317 hours, an interview with the RD was conducted. The RD stated the residents were expected to receive the right diet texture as noted on their meal ticket. The RD further stated the consistency between the regular and mechanical soft were different and may affect the resident's appetite. 8. On [DATE] at 1102 hours, a concurrent observation and interview was conducted with the DSS. The DSS was observed transferring the wheat flour in an open container without a lid from the dry storage room located at the back of the facility and back into the kitchen. The DSS verified the wheat flour was exposed during the transportation and stated the container should be covered since the flies could go inside and for infection control. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1317 hours, an interview with the RD was conducted. The RD stated the protocol when transporting opened food items was to have it covered especially when coming from outside, there was a risk for a fly to land on the food. On [DATE] at 1550 hours, an interview with the DON was conducted. The DON acknowledged all of the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46807 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for three of 14 final sampled residents (Residents 26, 32, and 35) was complete and accurate. * The facility failed to ensure an active physician's orders for Resident 26 to continue no weight bearing status to the left upper extremity and to continue to use a left arm sling for support were discontinued. * The facility failed to ensure Resident 35's physician's order for Dulcolax (laxative) medication was accurate. These failures had the potential for the resident's accurate clinical status not being available and communicated to care team. Findings: Review of the facility's P&P titled Charting and Documentation revised July 2017 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Medical record review for Resident 26 was initiated on 4/2/24. Resident 26 was readmitted to the facility on [DATE]. Review of Resident 26's H&P examination dated 10/7/23, showed Resident 26 had the capacity to understand and make decisions. Review of Resident 26's Physician's Orders for April 2024 showed a physician's order dated 12/21/23, to continue the status of no weight bearing on Resident 26's left upper extremity, and to continue to use left arm sling for support. In addition, Resident 26 had a diagnosis for two-part displaced fracture of the surgical neck of the left humerus. On 4/4/24 at 0911 hours, Resident 26 was observed without a sling support to his left upper extremity. CNA 3 verified Resident 26 was not wearing a left upper extremity sling support. Resident 26 stated his orthopedic physician told him that he did not have to use the sling support eight days after his fall last December 10th. Resident 26 stated he had not worn his sling support since then. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 0918 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated the active orders for Resident 26's no weight bearing status and sling support to the left upper extremities should had been discontinued. The DON stated she remembered the orders should be discontinued and the license nurses forgot to remove the orders. 2. Medical record review for Resident 35 was initiated on 4/3/24. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 5/10/23, showed Resident 35 had the capacity to understand and make decisions. Review of Resident 35's Physician's Orders for April 2024, showed the following physician's orders: -dated 2/13/24, to administer bisacodyl (Dulcolax, a laxative stimulant medication) 10 mg suppository daily as needed if Milk of Magnesia (MOM, a laxative stimulant medication) was not effective for constipation. -dated 2/13/24, to administer Fleet Enema (a laxative stimulant medication) one bottle daily as need for constipation if Dulcolax suppository was ineffective. -dated 2/13/24, to administer docusate sodium (a stool softener medication) 100 mg tablet and give one tablet by mouth twice a day as needed for constipation. However, further review of Resident 35's Physician's Orders for April 2024 did not show an order for MOM. On 4/5/24 at 0752 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the order was inaccurate. RN 1 stated the order should had been to administer MOM daily as needed and not the docusate sodium medication. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings. 44175 3. Medical record review for the Resident 32 was initiated on 4/2/24. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/2/24 at 1233 hours, during dinning observation, Resident 32 was observed eating his lunch in his room. The meal tray was observed with white bread with herbs, zesty lasagna, green beans, one banana, 8 oz of boost, a cup of chicken noodle soup, a cookie, a cup of grape juice and a cup of water. Resident 32 was observed eating one cup of chicken noodle soup, 8 oz of boost, a bite of cookie and half banana. Resident 32 was not observed eating main portion of the meal bread with herbs, zesty lasagna, green beans, a cup of grape juice and water. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 1255 hours, an observation and a concurrent interview was conducted with the IP. The IP was observed asking Resident 32 if he was done with his meal, Resident 32 stated yes. The IP then was observed taking out the tray of Resident 32's meal. The IP verified Resident 32 ate less than 50% of his meal tray. The IP was not observed offering alternative meal to Resident 32. Review of Resident 32's Completed Care Details showed on 4/2/24 at 1332 hours, the percentage of lunch eaten by Resident 32 was documented as 100%. On 4/5/24 at 1456 hours, an interview and concurrent medical record review for Resident 32 was conducted with the IP. The IP verified the above findings and stated the CNA should not documented Resident 32 ate 100% of their lunch, when they did not observe the amount of the lunch eaten by Resident 32 on 4/2/24. The IP stated she should have documented lunch amount eaten by Resident 32 on 4/2/24. On 4/5/24 at 1510 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F692.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the hospice and facility staff worked collaboratively together in the plan of care for two of three hospice residents (Residents 20 and 36) as per the hospice contract agreement. This failure had the potential of Residents 20 and 36 to not receive hospice care as per the hospice agreement. Findings: 1. Medical record review for Resident 20 was initiated on 4/2/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 11/7/23 showed Resident 20 had nocapacity to understand and make decisions and goals for comfort care. Review of Resident 20's Physician's Orders for April 2024 showed an order dated 11/7/23, to admit the resident to the facility under Hospice A. Review of Hospice A Contract Agreement dated 11/6/23, showed if providers schedule service specific IDT meetings, they will allow the agency personnel to participate in these and notify the agency of the scheduled dates of these meetings. All participants will be subject to patient confidentiality policy per this agreement. The agreement further showed both the plan of care and the nursing care plan developed by the agency will be part of the patients record in the facility. Both of these will be developed in collaboration with the agency and facility staff. The facility staff will notify the agency if there are any changes in the plan of care or the nursing care plan and make copies of these changes available to the agency personnel. On 4/4/24 at 0919 hours, a concurrent interview and medical record review with the IP was conducted. The IP verified Resident 20 was under Hospice A services. Review of Resident 20's care plans showed no documented evidence the hospice care team reviewed or acknowledged Resident 20's care plans. The IP stated since the hospice care team was also providing care to the hospice residents, they would also need to be updated and informed of the resident's care plans. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged above findings. 2. Medical record review for Resident 36 was initiated on 4/2/24. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 11/7/23, showed Resident 36 had no capacity to understand and make decisions. Review of Resident 36's Physician's Orders for April 2024, showed an order dated 9/1/23, to admit the resident to the facility under Hospice B. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospice B Certification of Terminal Illness dated 3/13/24, showed to continue to provide comfort measures per the hospice protocol. On 4/4/24 at 0919 hours, a concurrent interview and medical record review with the IP was conducted. The IP verified Resident 36 was under Hospice B services. The IP also verified the care plans for Resident 36 was not signed off by the hospice care team. The IP could not show documented evidence the hospice care team was aware of new and updated care plans for Resident 36. Further review of Resident 36's medical record showed the Quarterly IDT note dated 1/23/24, showed no documented evidence the hospice staff had participated in the IDT. The IP stated the hospice care team should be part of the IDT meetings and review of the care plans to ensure they and the facility were in agreeance of the resident's plan of care. On 4/4/24 at 1455 hours, an interview with the DON was conducted. The DON stated her expectation for hospice was for the hospice care team to participate in the IDT meetings during admission, quarterly, annually, and PRN (as needed) upon request by the resident's family member. The DON also verified the hospice care team did not sign the care plans after reviewed and agreed upon. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged the above findings. Cross reference to F684.

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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** 47474 Based on observation, interview, facility P&P review, and facility document review, the facility failed to establish and maintain the infection control program and practices designed to help prevent the development and transmission of diseases and infections as evidenced by: * The facility failed to ensure the EBP (Enhanced Barrier Precautions) was practiced for the residents with an indwelling urinary catheter (Resident 20) and GT (Residents 2, 9, and 36). * The facility failed to ensure LVN 2 wore proper PPE when administering medication through a GT for Resident 3. * The facility failed to ensure the Yankuer Suctioning (oral suctioning tool) was stored separately with opened date for Resident 11. * The facility failed to ensure LVN 1 performed hand hygiene in between changing gloves when providing wound treatment to Resident 22. In addition, the facility failed to ensure staff practiced the enhanced based precaution for Resident 22 who had a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) wound and an infected left hip surgical wound. These failures posed the risk for transmission of disease-causing microorganisms and infections to the residents. Findings: Review of the CMS's QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes dated 3/20/24 and effective 4/1/24, showed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The QSO further showed EBP recommendations now include use of EBP for the residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. 1a. Medical record review for Resident 20 was initiated on 4/2/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's medical record showed a physician's order dated 11/7/23, showed Resident 20 had an indwelling urinary catheter with a size 20 Fr/10 ml. On 4/2/24 at 0849 hours, an initial observation of the facility was conducted. Resident 20 was observed with an indwelling urinary catheter. Observation of Resident 20's room showed no evidence of EBP signage or PPE availability. b. Medical record review for Resident 2 was initiated on 4/2/24. Resident 2 was admitted to the facility on [DATE], and readmitted back to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's medical record showed a physician's order dated 12/5/23, showed the resident had a GT. Further review of Resident 2's medical record showed the resident was on GT feeding formula, Fibersource HN 1.2 at 40 ml/hr for 20 hours. On 4/2/24 at 0913 hours, an initial observation of the facility was conducted. Resident 2 was observed with a GT. Observation of Resident 2's room showed no evidence of EBP signage or PPE availability. c. Medical record review for Resident 9 was initiated on 4/2/24. Resident 9 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 9's medical record showed a physician's order dated 5/20/23, showed the resident had a GT. Further review of Resident 9's medical record showed the resident was on GT feeding formula, Jevity 1. 5 at 40 ml/hr via GT for 20 hours. On 4/2/24 at 0842 hours, an initial observation of the facility was conducted. Resident 9 was observed with a GT. Observation of Resident 9's room showed no evidence of EBP signage or PPE accessibility. d. Medical record review for Resident 36 was initiated on 4/2/24. Resident 36 was admitted to the facility on [DATE]. Review of Resident 36's medical record showed a physician's order dated 9/1/23, showed the resident had a GT. Further review of Resident 36's medical record showed the resident was on GT feeding formula, Jevity 1. 5 at 50 ml/hr via GT for 20 hours. On 4/2/24 at 0936 hours, an initial observation of the facility was conducted. Resident 36 was observed with GT. Observation of Resident 36's room showed no evidence of EBP signage or PPE availability. On 4/4/24 at 0807 hours, an interview with CNA 5 was conducted. CNA 5 stated the facility did not observe EBP and the facility did not have any residents on isolation precautions. CNA 5 verified during care for his residents with indwelling urinary catheters or GT, including changing the residents and emptying out the indwelling urinary catheter bag, CNA 5 stated he did not don on gown; however, only wore gloves. On 4/4/24 at 0918 hours, an interview with the IP was conducted. The IP verified the facility had the residents with the indwelling urinary catheter, GT, and wounds. The IP verified the facility did not have any residents on EBP. The IP further stated the residents with an indwelling urinary catheters and GT were at risk for bodily fluids to splash onto staff during care and stated EBP should be used. The IP stated she would set up isolation carts to have gown and gloves availability more accessible to staff and EBP signage outside the residents' rooms to identify the residents on EBP. The IP acknowledged it was important for the staff to be informed of EBP to protect themselves, the residents, other staff members, and visitors against transmission-based infections. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 1109 hours, a concurrent observation and interview with the DON was conducted outside of Resident 20's room. The DON verified Resident 20 had an indwelling urinary catheter and there were no EBP signage or isolation cart to provide PPE including gowns. The DON stated EBP was not practiced at the facility; however, she was aware the residents with an indwelling urinary catheters, GT, central lines, colostomy, wounds needed standard EBP precautions, including the use of gown and gloves during treatment, medication administration for the residents with GT, and changing the residents or emptying out the indwelling urinary catheters. The DON further stated use of the EBP help prevent transmission of diseases and ensures infection control would be maintained. 46807 2. Review of the facility's P&P titled Handwashing/Hand Hygiene revised August 2019 showed all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. after removing gloves. According to the QSO-24-08-NH with subject of Barrier Precautions in Nursing Home dated 3/20/24, showed the resident who has wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDROs should use Enhanced Barrier Precautions. Review of the facility's signage for the Enhanced Standard Precaution showed for the six groups of care activities (morning and evening care; toileting and changing incontinence briefs; caring for devices and giving medical treatments; wound care; mobility assistance and preparing to leave room; and cleaning the environment), to use hand hygiene, gloves, and gowns. a. During a wound treatment observation of Resident 22's infected left surgical hip wound on 4/3/24 at 1524 hours, LVN 1 was observed removing soiled gloves after patting the left hip surgical wound. LVN 1 was observed donning new gloves without performing any form of hand hygiene. LVN 1 was then observed reaching in her pocket with the same gloves to grab a pen and she wrote the date in the dry dressing. LVN 1 then applied the dated dry dressing on Resident 22's left hip surgical wound. LVN 1 was once again observed removing her gloves and donned new gloves without performing any type of hand hygiene. Then, LVN 1 was observed removing her gloves after cleaning Resident 22's Stage 4 pressure ulcer to her midback and donned new gloves without performing any type of hand hygiene prior to applying the Santyl (ointment medication used to removed damaged tissue from chronic skin ulcers or severely burned areas) to wound. Medical record review for Resident 22 was initiated on 4/3/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 3/21/24, showed Resident 22 had the capacity to understand and make decisions. Review of Resident 22's Physician's Orders for April 2024, showed the following physician's orders: - dated 3/19/24, to cleanse midback Stage 4 with normal saline, pat dry, apply Santyl ointment, and apply dry dressing daily for 30 days and reevaluate on 4/11/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 4/2/24, to cleanse left hip surgical incision with 21 staples with normal saline, pat dry and apply dry dressing for 14 days, and reevaluate for 14 days on 4/16/24. On 4/3/24 at 1545 hours, an interview was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated she was supposed to wash her hands when she changed her old gloves to a new gloves. On 4/4/24 at 0756 hours, an interview was conducted with the IP. The IP stated the staff was expected to at least perform an alcohol-based hand rub or wash their hands any time the staff changes gloves and don new gloves. b. During a wound treatment observation of Resident 22's Stage 4 pressure ulcer to midback and infected left surgical hip wound on 4/3/24 at 1524, Resident 22 was observed not placed on enhanced barrier precaution. On 4/4/24 at 1043 hours, an observation and concurrent interview was conducted with the IP. The IP verified the above findings. The IP stated the residents with wounds, GTs, or any opening that can cause splashes should be placed on enhanced standard precautions. The IP stated Resident 22 should be placed on an enhanced standard precautions due to her Stage 4 pressure ulcer and infected left hip surgical incision wounds. The IP stated there should be a signage outside Resident 22's room and an isolation cart with gloves and gowns. The IP further stated staff should be performing hand hygiene before and after direct care, don gloves, and gown. The IP stated she did not have any residents on enhanced standard precautions, and she was aware of the Quality Safety and Oversight (QSO, a memoranda, guidance, clarification, and instructions to State Survey Agencies and CMS locations) for enhanced barrier precautions. On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings. Cross reference to F882, example #2. 44175 3. On 4/3/24 at 0845 hours, a medication pass observation was conducted with LVN 2. LVN 2 was observed preparing the following medications for Resident 3: - Amantadine (medication to treat Parkinson's disease) 50 mg/ml 5 ml. - Decousate sodium (stool softer) two tablets. - Rivastigiminie 9.5 mg (medicine to treat dementia) transdermal system (a technique that provides drug absorption via the skin). -Oxybutynin 50 mg (a medicine used to treat symptoms of an overactive bladder) one tablet. -Carbidopa levodepa (medication to treat Parkinson disease) 10-100 mg one tablet. -Vitamin D3 25 mcg two tablets. - Vitamin C 500 mg two tablets. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Multivitamin with minerals one tablet. - Potassium Chloride 20 meq/15 ml, mixed with 120 ml of water. - Multivitamin minerals one tablet. LVN 2 crushed the tablets separately mixed each crushed medications with 5 mls of water in a medication cup and put it in a tray. LVN 2 entered the room with the medications on tray and closed the curtain for Resident 3's privacy. LVN 2 then performed hand hygiene, donned a clean pair of gloves, confirmed g-tube placement and administered medications through the GT each medication separately with 5 ml of flush in between each medications. LVN 2 was observed not wearing gown before administering medication through the GT. On 4/4/24 at 0745 hours, an interview was conducted with LVN 2. LVN 2 verified the above observation and stated she did not wear gown before she administered the medications through the GT. LVN 2 stated she wore gloves as a standard precaution and Resident 3 was not on any isolation precautions. When asked LVN 2 if Resident 3 required enhanced barrier precaution, she stated she was not aware about the enhanced barrier precaution required for the residents with a GT. On 4/4/24 at 0801 hours, an interview was conducted with the DON. The DON was informed of the above findings. The DON acknowledged the above findings and stated she was aware about the enhanced barrier precaution; however, she thought that was a recommendation not the requirement, so the facility did not put the residents with a GT on the enhanced barrier precautions. The DON stated she would review the new QSO for enhanced barrier precaution for nursing home. On 4/4/24 at 1331 hours, a follow-up interview was conducted with the DON. The DON stated she reviewed QSO on enhanced barrier precaution. The DON stated Resident 3 had a GT and required enhanced barrier precautions. The DON further stated the LVN should have worn gown in addition to the gloves before administering medication through a GT for Resident 3. Medical record review for Resident 3 was initiated on 4/3/24. Resident 3 was admitted to the facility on [DATE], with diagnoses which included gastrotomy status (an artificial external opening into the stomach). 4. On 4/2/24 at 0917 hours, during the observation at Resident 11's left side of the bed, the opened yankauer suction connected to the tubing attached to the suction machine was observed. The yankauer suction was observed stored in a bag with miscellaneous items with no label. On 4/2/24 at 0939 hours, a concurrent observation and interview was conducted with the IP. The IP verified the observation and stated the yankuer suction was being used for the Resident 11 and should have been stored in a separate bag with a label. The IP further stated not labeling yankuer suction and storing it with miscellaneous items could create a source of infection for Resident 11. On 4/4/24 at 0808 hours, an interview was conducted with the DON. The DON acknowledged the above findings and stated the yankuer suctioning should be one time use, if it was not visibly dirty then it should be changed every shift. The DON further stated the Licensed Nurses should have labeled the yankuer suctioning with the date opened and stored in a separate bag.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the IP had the knowledge of the Pneumococcal immunization update per the CDC's guidelines. In addition, the facility failed to ensure the IP had the appropriate knowledge to implement the enhanced barrier precautions with the facility's residents needed to be placed on a special precautions. These failures had the potential for the residents not to receive timely the appropriate type of pneumonia immunization placing the residents at risk for developing pneumonia (infection of the lungs that causes inflammation of air sacs in one or both lungs which may fill with fluid), and potential for spread of infection. Findings: Review of the facility's P&P titled Pneumococcal Vaccine dated October 2019 showed all the residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessment of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regrading the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of the IP's training showed the IP was certified on the Nursing Home Infection Preventionist Training Course on 8/30/20, and another Certificate of Completion on Healthcare-Associated Infections on 2/10/24. Review of the IP's Job Description and Evaluation form dated July 2016 conducted and signed by the Supervisor/Administrator on date of hire 8/20/20, showed the primary purpose of this position is to plan, organize, develop, coordinate, and direct the infection prevention and control program and its activities in accordance with current federal, state, and local standards, guidelines, and regulations that govern such programs, and as maybe directed by the administrator and the infection Prevention and Control Committee to ensure that an effective infection prevention and control program is maintained at all times. Specific requirements included the IP must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations and guidelines that pertain to nursing care facilities and infection prevention and control practices, to include standard/universal precautions. Review of the new CDC guideline titled (MMWR) Morbidity and Mortality Weekly Report dated 1/28/22, showed use of 15-Valent Pneumococcal Conjugate Vaccine and 20- Valent Pneumococcal Conjugate Vaccine among U.S. Adults: Updated Recommendations of the Advisory Committee on Immunization Practices (APIC) - United States , 2022. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the CMS's QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes dated 3/20/24, and effective 4/1/24, showed, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The QSO further showed EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. 1. On 4/05/24 at 1033 hours, an interview and concurrent document review was conducted with the IP. The IP was asked about the type of (PNA) Pneumonia vaccine given to the residents. The IP had given PPSV 23 Pneumococcal Polysaccharide Vaccine) did not offer the PCV 15 or 20 (Pneumococcal Conjugate Vaccine). The IP stated she has no awareness of the current PNA vaccine per the CDC guideline and was not tracking the type of vaccine the residents need based on the new CDC guidelines. The IP was asked if facility offered anything else for pneumonia such as PCV 13, 15, or 20. The IP stated the facility did not offer PCV 13,15, or 20; and offered only PPSV 23 to all the residents. Review the CDC Pneumococcal website about Pneumococcal vaccine was conducted with the IP. When asked, the IP stated the CDC recommended PCV 15 or 20 and they were not doing this. 46807 2. Medical record review for Resident 22 was initiated on 4/3/24. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 3/21/24, showed Resident 22 had the capacity to understand and make decisions. Review of Resident 22's Physician's Orders for April 2024 showed the following physician's orders: - dated 3/19/24, to cleanse the midback Stage 4 with normal saline, pat dry, apply Santyl (wound debridement agent)ointment, and apply a dry dressing daily for 30 days and re-evaluate on 4/11/24. - dated 4/2/24, to cleanse the left hip surgical incision with 21 staples with normal saline, pat dry and apply a dry dressing for 14 days, and re-evaluate for 14 days on 4/16/24. During the wound treatment observation of Resident 22's Stage 4 pressure ulcer to the midback and infected left surgical hip wound on 4/3/24 at 1524 hours, Resident 22 was observed not placed on the enhanced barrier precaution. On 4/4/24 at 1043 hours, an observation and concurrent interview was conducted with the IP. The IP verified the above findings. The IP stated the residents with wounds, GTs, or any opening that can cause splashes should be placed on the enhanced standard precautions. The IP stated Resident 22 should be placed in an enhanced standard precautions due to her Stage 4 pressure ulcer and infected left hip surgical incision wounds. The IP stated there should be a signage outside Resident 22's room and an isolation cart with gloves and gowns. The IP further stated the staff should be performing hand hygiene before and after direct care, don gloves and gown. The IP stated she did not have any residents on enhanced standard precautions, and she was aware of the Quality Safety and Oversight (QSO, a memoranda, guidance, clarification, and instructions to State Survey Agencies and CMS locations) for enhanced barrier precautions. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/5/24 at 1530 hours, the DON was informed and acknowledged the above findings. On 4/10/24 at 1012 hours, an interview was conducted with the Administrator. The Administrator stated he expected the IP to report in the quarterly assurance meeting the antibiotic stewardship program, any use and discontinuation of antibiotic medications, any patterns of infection, COVID 19 cases in the facility, vaccination information, and any new infection prevention and control updates that affects the facility and the residents. The Administrator stated he knew there were six moments to follow the enhanced barrier precautions. The Administrator further stated the IDT was not aware of the enhanced barrier precaution not being implemented for appropriate residents in the facility. The Administrator stated he expected the IP to report this information in the QA meeting so the facility could prevent issues of spreading infections. Cross reference to F880, example #2. 47474 3. On 4/4/24 at 0918 hours, an interview was conducted with the IP. The IP verified the facility did not have any residents on EBP; however, the IP stated the facility had the residents with the indwelling urinary catheters and GT. The IP further stated the residents with the indwelling urinary catheters and GT had a risk for bodily fluids to splash onto staff during care and stated the EBP should have been used. The IP denied the charge nurses using the proper PPE with use of gown and glove when doing the GT medication administration. Moreover, the IP acknowledged it was important for the staff to be informed of the EBP to protect themselves, the residents, other staff members, and visitors against transmission-based infections and to help minimize the spread of infection. On 4/4/24 at 1109 hours, an interview with the DON was conducted. The DON verified the facility had the residents with indwelling urinary catheters, GT, and wounds; however, they did not have the residents on EBP. The DON stated she received the current infection control guidelines from the IP. The DON stated she relied on the IP for the current infectious control guidelines and protocols prior to initiating in the facility. However, the DON stated the IP did not notify her of the current CMS guidelines for EBP effective on 4/1/24. The DON further stated the use of EBP would help prevent the transmission of diseases and ensures infection control would be maintained. Cross reference to F880 example #1.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48332 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer PCV 15/PCV 20 (PCV 15 protects against two additional serotypes and PCV 20 protects against seven additional serotypes involved in cases of invasive pneumococcal disease (IPD) and pneumonia) immunizations for 20 of 20 nonsampled residents (Residents 1, 3, 4, 5, 6, 8, 13, 15, 16, 18, 19, 21, 23, 24, 25, 27, 29, 30, 31, and 33) reviewed for pneumococcal vaccination (a vaccine given to protect the resident from pneumococcal disease) in accordance with the CDC's recommendations. No tracking system was in place for pneumococcal vaccine history. These failures increased the residents' risk for being inadequately vaccinated for the pneumococcal disease and its associated complications. Findings: Review of the new CDC guideline titled (MMWR) Morbidity and Mortality Weekly Report dated 1/28/22, showed use of 15-Valent Pneumococcal Conjugate Vaccine and 20-Valent Pneumococcal Conjugate Vaccine among U.S. Adults: Updated Recommendations of the Advisory Committee on Immunization Practices (APIC) - United States, 2022. Review of the CDC Morbidity and Mortality Weekly Report titled Use of 15-Valent Pneumococcal Conjugate Vaccine (PCV 15) and 20-Valent Pneumococcal Conjugate Vaccine (PCV 20) Among U.S. Adults: Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP) dated 1/28/22, showed the ACIP recommended PCV15 or PCV20 for adults who are either aged [AGE] years and older or aged 19-[AGE] years with certain underlying conditions. When PCV15 is used, it should be followed by a dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23), typically one year later. The previous CDC's pneumococcal vaccine guidelines, prior to 1/2022 update, was recommendations for pneumococcal vaccination (PCV13 or Prevnar13(R), and PPSV23 or Pneumovax23(R)) for all adults [AGE] years or older. For adults [AGE] years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23. Review of the CDC's guidelines for pneumococcal vaccination reviewed 9/22/23, showed the following: - for adults [AGE] years or older who had never received any pneumococcal vaccine regardless of risk conditions, give one dose of PCV 15 or PCV 20 (PCV 15 protects against two additional serotypes and PCV 20 protects against seven additional serotypes involved in cases of invasive pneumococcal disease (IPD) and pneumonia). When PCV 15 is used, it should be followed by a dose of PPSV 23 (pneumococcal polysaccharide vaccine, use for protected adults and children older than 2 years of age against invasive disease caused by the 23 capsular serotypes contained in the vaccine) at least one year later. The minimum interval (eight weeks) can be considered in adults with an immunocomprising condition, cochlear implant, or cerebrospinal fluid leak. Their vaccines will then be complete. When PCV 20 is used, it does not need to be followed by a dose of PPSV 23. Their vaccines are then completed. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- for adults [AGE] years or older who had only received PPSV 23 regardless of risk condition, give one dose of PCV 15 or PCV 20 at least one year after the most recent PPSV 23 vaccination. Regardless of vaccine given, an additional dose of PPSV 23 is not recommended since they already received it. Their vaccines are then completed. Review of the facility's P&P titled Pneumococcal Vaccine revised October 2019 showed all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, the residents will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessment of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of Residents 1, 4, 3, 5, 6, 8, 13, 16, 18, 19, 21, 23, 24, 25, 29, 30, and 33 for pneumococcal immunization records were conducted on 4/9/24. Review of the Pneumococcal informed consents showed all of these residents received the information on pneumococcal infections and education on the risks and benefits associated with PPSV 23. There was no information about PCV 15 and PCV 20. The immunization records showed the residents received PPSV 23 vaccine as follows: - Resident 1 received PPSV 23 on 6/14/21. - Resident 3 received PPSV 23 on 3/6/20. - Resident 4 received PPSV 23 on 6/14/21. - Resident 5 received PPSV 23 on 6/10/21. - Resident 6 received PPSV 23 on 3/20/24. - Resident 8 received PPSV 23 on 11/28/23. - Resident 13 received PPSV 23 on 01/27/23. - Resident 16 received PPSV 23 on 6/10/21. - Resident 18 received PPSV 23 on 6/10/21. - Resident 19 received PPSV 23 on 6/11/21. - Resident 21 received PPSV 23 on 9/1/20. - Resident 23 received PPSV 23 on 5/1/22. - Resident 24 received PPSV 23 on 6/11/21. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Resident 25 received PPSV 23 on 5/1/22. - Resident 29 received PPSV 23 on 02/10/23. - Resident 30 received PPSV 23 on 1/1/23. - Resident 33 received PPSV 23 on 2/1/23. 1. Medical record review for Resident 5 was initiated on 4/9/24. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Physician order dated 6/8/21, showed the facility may give the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23). Review of Resident 5's Resident Immunization Record form (undated) showed Resident 5 received the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23) at the facility on 6/10/21. Further review of Resident 5's medical record failed to show Resident 5 was offered the PCV 15 or PCV 20 vaccines after receiving the PPSV 23 as per the CDC's guidelines. 2. Medical record review for Resident 13 was initiated on 4/9/24. Resident 13 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 13's Physician order dated 1/15/23, showed the facility may give Resident 13 the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23). Review of Resident 13's Pneumococcal Pneumonia Immunization Program Consent Form dated 1/26/23, showed the signed consent for Resident 13 to receive the pneumococcal vaccine. Review of Resident 13's Resident Immunization record form (undated), showed Resident 13 received the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23) at the facility on 1/27/23. Further review of Resident 13's medical record failed to show Resident 13 was offered the PCV 15 or PCV 20 vaccines after receiving the PPSV 23 as per the CDC guidelines. 3. Medical record review for Resident 4 was initiated on 4/9/24. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Physician order dated 6/8/21, showed the facility may give Resident 4 the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23). Review of Resident 4's Pneumococcal Pneumonia Immunization Program Consent Form dated 6/12/21, showed a verbal consent was received from Resident 4's responsible party to give Resident 4 the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23). Review of Resident 4's Resident Immunization record form (undated) showed Resident 4 received the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23) in the facility on 6/14/21. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of Resident 4's medical record failed to show Resident 4 was offered the PCV 15 or PCV 20 vaccines after receiving the PPSV 23 as per the CDC's guidelines. 4. Medical record review for Resident 29 was initiated on 4/9/24. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's Physician order dated 2/18/23, showed the facility may give Resident 29 the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23). Review of Resident 29's Resident Immunization record form (undated) showed Resident 29 received the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23) in the facility on 2/20/23. Further review of Resident 29's medical record failed to show Resident 29 was offered the PCV 15 or PCV 20 vaccines after receiving the PPSV 23 as per the CDC's guidelines. 5. Medical record review for Resident 24 was initiated on 4/9/24. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's Physician order dated 6/8/21, showed the facility may give Resident 24 the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23). Review of Resident 24's Pneumococcal Pneumonia Immunization Program Consent Form dated 6/10/21, showed the signed consent for Resident 24 to receive the pneumococcal vaccine. Review of Resident 24's Resident Immunization record form (undated) showed Resident 24 received the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23) in the facility on 6/11/21. Further review of Resident 24's medical record failed to show Resident 24 was offered the PCV 15 or PCV 20 vaccines after receiving the PPSV 23 as per the CDC's guidelines. 6. Medical record review for Resident 1 was initiated on 4/9/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Physician order dated 6/14/21, showed the facility may administer Resident 1 the Pneumovax 23 (Pneumococcal Polysaccharide Vaccine 23). Review of Resident 1's Pneumococcal Pneumonia Immunization Program Consent Form dated 6/14/21, showed the signed consent for Resident 1 to receive the pneumococcal vaccine. Review of Resident 1's Resident Immunization record form (undated) showed Resident 1 received the Pneumococcal Polysaccharide Vaccine 23 (PPSV 23) in the facility on 6/14/21. Further review of Resident 1's medical record failed to show Resident 1 was offered the PCV 15 or PCV 20 vaccines after receiving the PPSV 23 as per the CDC's guidelines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/05/24 at 1033 hours, an interview was conducted with the IP (Infection Preventionist). The IP was asked what are the types of (PNA) Pneumonia vaccine was given to the residents. The IP stated she had only given the PPSV 23 (Pneumococcal Polysaccharide Vaccine) to the above residents (Residents 1, 4, 5, 13, 24, and 29), and did not offer the PCV 15 or PCV 20 (Pneumococcal Conjugate Vaccine). The IP stated she had no awareness of the current PNA vaccine as per the CDC's guidelines and was not tracking the type of vaccine the residents need based on the new CDC's guidelines. The IP stated she offered the PPSV 23 only because the consent for PNA vaccine offered only PPSV 23 to all the residents. The facility Pneumococcal Pneumonia Immunization Program Consent Form showed the Pneumococcal Polysaccharide Vaccine was effective against 23 pneumococcal types which caused 90 percent of all pneumococcal pneumonia and was effective for approximately six years. Anyone [AGE] years of age or older or having chronic health problems were considered as high risk for exposure to and complications from pneumococcal pneumonia. On 4/09/24 at 0829 hours, further interview, concurrent medical record review, and document review was conducted with the IP and DON (Director of Nursing). The IP was asked about the facility tracking system for PNA vaccine and the list of the residents' pneumonia vaccine status. The IP provided the list, but the document did not show the specific type of pneumonia vaccine given, it just showed, Pneumonia; which was similar to what was written in the medical record. The IP and the DON verified and acknowledged the findings. The IP stated the facility was not listing the specific pneumonia vaccine administered, and the facility should. 46807 7. Medical record review for Resident 6 was initiated on 4/9/24. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P (History and Physical) examination dated 2/24/24, showed Resident 6 could make needs known but could not make medical decisions. Review of Resident 6's Resident Immunization Record Form (undated) showed Resident 6 had received a pneumonia vaccination on 3/20/24. However, the form did not show what type of pneumonia vaccination was administered. Review of Resident 6's Pneumococcal Pneumonia Immunization Program Consent dated 2/14/24, showed Resident 6 agreed to receive the PPV 23 vaccination. Review of an email sent from a Veterans employee dated 2/20/24, showed a message that Resident 6 refused and needed his influenza and pneumonia vaccination. On 4/9/24 at 1333 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified the above findings. The IP stated she should had offered the PCV 20 per the CDC's guidelines so Resident 6 could had been updated with his pneumonia vaccination. However, the IP stated the pneumonia consent form only offered the PPV 23. 8. Medical record review for Resident 8 was initiated on 4/2/24. Resident 8 was readmitted to the facility on [DATE]. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 8's H&P examination dated 10/3/23, showed Resident 8 could make needs known but could not make medical decisions. Review of Resident 8's Resident Immunization Record Form (undated) showed Resident 8 received a pneumonia vaccination on 3/20/24. However, the form did not show what type of pneumonia vaccination was administered. Review of Resident 8's Pneumococcal Pneumonia Immunization Program Consent dated 3/22/24, showed Resident 8 signed the consent form. However, the consent form did not show if Resident 8 wanted or did not want to receive the pneumonia vaccination. Review of Resident 8's General Nurses Note dated 3/20/24, showed Resident 8 was given PPV (Pneumococcal Polysaccharide Vaccine) on his right deltoid as ordered by the resident's physician. A verbal consent was received from Resident 8's responsible party. On 4/9/24 at 1406 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified the above findings. The IP stated Resident 8 was updated with her pneumonia vaccination based on the consent which only presented the PPV 23. 9. Medical record review for Resident 21 was initiated on 4/3/24. Resident 21 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 21's Resident Immunization Record form (undated), showed Resident 21 received Pneumococcal polysaccharide vaccine (PPV) on 9/10/20, prior to admission to the facility. Review of Resident 21's Pneumococcal Pneumonia Immunization Program Consent Form was not completed. On 4/9/24 at 1415 hours, an interview and concurrent medical record review was conducted with the IP. The IP stated she should have had offered Resident 21 the option to receive the Pneumococcal Conjugate Vaccine 20 (PCV 20) to be up to date with her pneumococcal immunization. 10. Medical record review for Resident 25 was initiated on 4/9/24. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Resident Immunization Record form (undated) showed Resident 25 received a pneumonia vaccination on 5/10/22. However, the form did not show what type of pneumococcal vaccination was administered to Resident 25. Review of Resident 25's General Nurses Notes dated 5/9/22, showed pneumonia vaccination was offered to Resident 25 and he agreed to receive the pneumonia vaccine. Resident 25 could not recall if he had the pneumonia vaccine in the past. Resident 25's daughter did not have an idea if Resident 25 received the PPV vaccine before. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/9/24 at 1348 hours, an interview and concurrent medical records was conducted with the IP. The IP stated Resident 25's pneumococcal vaccination history information should had been unknown. The IP stated she only offered the residents the option to receive the PPV 23 because it was the only pneumococcal vaccination listed in the Pneumococcal Pneumonia Immunization Program Consent Form. The IP stated she should had offered the PCV 20 for Resident 25 be up to date with her pneumococcal immunization. 11. Medical record review for Resident 30 was initiated on 4/9/24. Resident 30 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 30's H&P examination dated 11/13/22, showed Resident 30 had no capacity to understand and make decisions. Review of Resident 30's Resident Immunization Record form (undated) showed Resident 30 received a pneumonia vaccination on 1/27/23. However, the form did not show what type of pneumococcal vaccination was administered to Resident 30. Review of Resident 30's General Nurses Note dated 1/25/23, showed a new order from the physician for Resident 30 to receive a pneumonia vaccine. Resident 30 was made aware and signed the consent. Review of Resident 30's Pneumococcal Pneumonia Immunization Program Consent Form, (undated), showed both options for yes and no to receive the pneumococcal vaccine were checked off, the reason showed the resident had it. On 4/9/24 at 1423 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified the above findings. The IP stated she should have had offered the PCV 20 because it was more than a year ago that Resident 30 received the PPV 23 if she followed the updated CDC's guidelines. The IP stated she offered the PPV 23 to Resident 30 because that was the only pneumonia vaccine offered in the pneumonia consent the facility had provided. On 4/10/24 at 1310 hours, the DON was informed and acknowledged all the above findings. Cross reference to F641 for examples #1 and #2. 44175 12. Medical record review for Resident 3 was initiated on 4/3/24. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 11/22/23, showed Resident 3 did not have the capacity to understand and make medical decisions. Review of Resident 3's Immunization Administration Record showed Resident 3 received pneumococcal vaccine on 3/6/20. The Immunization Administration Record for Resident 3 did not show the type of pneumococcal vaccine administered. Review of Resident 3's MAR (Medication Administration Record) dated March 2020 showed Resident 3 was administered PPSV23 on 3/6/20. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Resident 3's General Nurses Notes dated 4/8/24 at 1733 hours, showed Resident 3's responsible party was called and offered PCV 20, educated on the pneumococcal vaccination, and declined the vaccination. Further review of Resident 3's medical record did not show if Resident 3 was offered PCV 20 single dose or PCV 15 followed by PPSV23, until 4/8/24. 13. Medical record review for Resident 16 was initiated on 4/9/24. Resident 16 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 7/29/23, showed Resident 16 had the capacity to understand and make decisions. Review of Resident 16's MAR dated June 2021 showed Resident 16 was administered with PPSV23 on 6/10/21. Further review of the medical record for Resident 16 did not show if Resident 16 was offered PCV 20 single dose or PCV 15 followed by PPSV23. 14. Record review for Resident 19 was initiated on 4/9/24. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 8/27/23, showed Resident 19 did not have the capacity to understand and make decisions. Review of Resident 19's undated Immunization Administration Record showed Resident 19 received Pneumococcal vaccine on 6/11/21, and PCV 20 on 4/6/24. The Immunization Administration Record for Resident 19 did not show the type of the pneumococcal vaccine administered on 6/11/21. Review of Resident 19's MAR dated June 2021 showed Resident 19 received PPSV23 on 6/11/21. Further review of Resident 19's medical record did not show if Resident 16 was offered PCV 20 single dose or PCV 15 followed by PPSV23, until 4/6/24. 15. Medical record review for Resident 23 was initiated on 4/9/24. Resident 23 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 23 H&P examination dated 3/13/24, showed Resident 23 had the capacity to understand and make decisions. Review of Resident 23's undated Immunization Administration Record showed Resident 23 received pneumococcal vaccine on 5/10/22, and PCV 20 on 4/6/24. The Immunization Administration Record for Resident 19 did not show the type of the pneumococcal vaccine administered on 5/10/22. Review of Resident 23's MAR dated May 2022 showed Resident 23 received PPSV23 on 5/10/22. Further review of Resident 23's record did not show if Resident 23 was offered PCV 20 single dose or PCV 15 followed by PPSV23, until 4/6/24. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	16. Medical record review for Resident 27 was initiated on 4/9/24. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 1/15/24, showed Resident 27 could make needs known but could not make medical decisions. Review of Resident 27's undated Resident Immunization Record did not show an entry for the pneumococcal vaccination. Review of Resident 27's General Nurses Note dated 2/14/24, showed the facility called Resident 27's responsible party to inquire about the resident's vaccination status and was awaiting to call back from the responsible party. Review of an email sent from a veterans employee dated 2/20/24, showed a message Resident 27 refused his influenza and pneumonia vaccination on 9/2023. Further review of the medical record for Resident 27 did not show if the facility followed up with responsible party to inquire about the Resident 27's pneumococcal vaccination status after 2/20/24, and if pneumococcal vaccination was offered to Resident 27. On 4/9/24 at 1447 hours, a concurrent interview, medical record review, and document review for Residents 3, 16, 19, 23, and 27 was conducted with the IP. The IP verified the above findings. The IP stated Residents 3, 16, 19, and 23 did not receive updated vaccination which was either PCV20 single dose, or PCV15 followed by PPSV 23 as recommended by APIC to be up to date with their pneumococcal immunization until 4/6/24. In addition, the IP stated she inquired about Resident 27's vaccination status and received an email from the previous facility Resident 27 declined the pneumococcal vaccination; however, she did not offer the pneumococcal vaccination in the facility. The IP stated she should have followed up with Resident 27's responsible party and offered Resident 27 the updated pneumococcal vaccine. The IP further stated Residents 19 and 23 received the updated pneumococcal vaccine PCV20 on 4/6/24. Furthermore, Resident 3's responsible party declined the offer for pneumococcal vaccination on 4/8/24, and she was working to provide the updated pneumococcal vaccination to other residents in the facility. On 4/10/24 at 0939 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F641 for examples #3, #4, #5, #6 and #7. 47474 17. Medical record review for Resident 15 was initiated on 4/9/24. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's annual MDS dated [DATE], showed Resident 15 had a BIMS score of 15 which meant the resident was cognitively intact. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 15's Resident Immunization Record Form, (undated), showed Resident 15 declined the pneumonia vaccine on 1/8/16. Further review of Resident 15's medical record showed no documented evidence Resident 15 was educated on the risk and benefits of the pneumonia vaccine, provided a VIS (Vaccine Information Statement) handout from the CDC, or signed a consent acknowledging a declination of the pneumonia vaccine. On 4/9/24 at 1517 hours, a concurrent interview and medical record review was conducted with the IP. The IP verified the above findings. The IP stated when the residents declined a vaccine, the staff would explain the risk and benefits; however, the IP could not show the documented evidence the risk and benefits of declining the pneumococcal vaccine or a VIS handout was provided to Resident 15. The IP further stated the pneumococcal consent form showed if a resident agreed or declined to receive the vaccine and should have been completed for Resident 15 after Resident 15 declined the pneumococcal vaccine. When asked if Resident 15 was offered the pneumococcal vaccine after the resident initially declined, the IP stated no. Moreover, the IP stated the residents who declined the pneumococcal vaccine should be offered yearly to keep the residents up to date and if the residents decided to receive, the pneumococcal vaccine could be provided. 18. Medical record review for Resident 33 was initiated on 4/9/24. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Quarterly MDS dated [DATE], showed Resident 33 has a BIMS score of 12 (moderately impaired). Review of Resident 33's Resident Immunization Record Form (undated) showed Resident 33 received a pneumonia vaccination on 2/10/23. However, the form did not show what type of pneumococcal vaccination was administered to Resident 33. Review of Resident 33's Physician's Telephone Order form showed Resident 33 had a physician's order to receive the Pneumovax 23 vaccine on 2/10/23. Review of Resident 33's Pneumococcal Pneumonia Immunization Program Consent form dated 2/8/23, showed Resident 33 agreed to receive the PPSV23 vaccine. On 4/9/24 at 1517 hours, a concurrent interview and medical record review was conducted with the IP. The IP verified the above findings. The IP stated she did not offer Resident 33 the PCV 20 or PCV 15; however, the IP stated she should have ensured Resident 33's pneumococcal immunization was current. 19. Medical record review for Resident 18 was initiated on 4/9/24. Resident 18 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 18's Quarterly MDS dated [DATE], showed Resident 18 had a BIMS score of 11 (moderately impaired). Review of Resident 18's Resident Immunization Record Form (undated) showed Resident 18 received a pneumonia vaccine on 6/10/21. However, the form did not show what type of pneumococcal vaccination was administered to Resident 18. Review of Resident 18's physician Orders List showed Resident 18 had a physician's order to receive the PPV23 vaccine on 6/10/21. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 18's Pneumococcal Pneumonia Immunization Program Consent form dated 6/8/21, showed Resident 18 agreed to receive the PPV23 vaccine. On 4/9/24 at 1517 hours, a concurrent interview and medical record review was conducted with the IP. The IP verified the above findings. The IP stated Resident 18 was only offered the PPSV23; however, the IP stated she should have offered Resident 18 the PCV20 to ensure pneumococcal vaccination was current. The IP stated as of 4/6/24, Resident 18 was offered and provided the PCV20. 20. Medical record review for Resident 31 was initiated on 4/9/24. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's Quarterly MDS dated [DATE], showed Resident 31's cognitive skills for daily decision making was assessed to be severely impaired (who never or rarely made decisions). Review of Resident 31's Resident Immunization Record Form (undated) showed Resident 31 received PPV on 6/4/21, outside of the facility. However, the form did not indicate what type of pneumonia vaccination was administered. Further review of Resident 31's Immunizations history form showed Resident 31 received the Pneumococcal conjugate PCV 13 on 6/4/21. On 4/9/24 at 1517 hours, a concurrent interview and medical record review was conducted with the IP. The IP verified the above findings. The IP stated Resident 31 was not up to date on her pneumococcal vaccination. The IP further stated Resident 31 was not offered the PCV20 or PPSV23 as per the CDC's recommendations after Resident 31 received the PCV13. On 4/10/24 at 1302 hours, an interview with the DON and Administrator was conducted. The DON and Administrator acknowledged the above findings. Cross reference to F641, examples #8, #9, #10, and #11.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to follow up when the residents' beds failed on the entrapment assessments zone for two of three residents reviewed for bed rails (Residents 9 and 32). * The facility failed to ensure Residents 9 and 32's side rails were reassessed after failed Zone 6 measurement was noted. This failure had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety revised on 12/2007, showed to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: a. Inspection by maintenance staff of all beds and related equipment as part of the regular bed safety program to identify risks and problems including potential entrapment risks. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Proper Use of Side Rails revised December 2016 showed an assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using the siderails. When used for mobility or transfer, an assessment will include a review of the resident's: - Bed mobility; - Ability to change positions, transfer to and from bed or chair, and to stand and toilet; - Risk of entrapment from the use of side rails; and, - That the bed's dimensions are appropriate for the resident's size and weight. The P&P further showed when side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used) and the resident will be checked periodically for safety relative to side rail use. Review of the facility's document titled Safety Assessment for Siderail Usage showed Zone 6 measurements was between the end of the rail and the side edge of the head or foot board or any V-shaped opening between the end of the rail and the head or foot board (risk of entrapment due to wedging). Review of the facility's undated document titled Side Rail Order showed the facility had 17 residents with the use of side rails, including Residents 9, and 32. 1. On 4/2/24 at 0824 hours, a concurrent observation and interview was conducted with Resident 32. Resident 32 was observed lying in bed, alert and awake, and bilateral half siderails was elevated. Resident 32 stated he did not use the siderails and was attached to the bed since he got admitted in the facility. On 4/4/24 at 0723 hours, a concurrent observation and interview was conducted with LVN 1. Resident 32 was observed alert, awake in bed with the bilateral half siderails was observed elevated. LVN 1 verified the observation. Medical record review for the Resident 32 was initiated on 4/2/24. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's Physician Orders showed an order dated 4/2/24, for bilateral 1/2 (half) side rails for mobility and repositioning. Review of the Resident 32's MDS dated [DATE], showed Resident 32 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 0833 hours, an interview and concurrent medical record review for Resident 32 was conducted with the IP. When asked about the bed inspection process, the IP stated she and the Administrator checked if there was a gap between the mattress and side rails, using the bed system measurement device annually. When asked if she and the Administrator inspected the bed when the side rails were initially ordered and installed, the IP stated facility only conducted the bed inspection annually. The IP stated when new resident gets admitted in the bed with siderails attached and if the resident request siderails to be elevated, then she looked back to the measurements and determine possible entrapment risk for the resident. Review of Bed Inspection (Measurements) dated 1/3/24 showed Bed #15. The IP verified Bed #15 corresponded to the bed Resident 32 was currently using, to which she and the Administrator checked the bedframe length, mattress length, mattress height, zone passed, and zone failed for the use of the siderails. Further review of the document showed Bed #15 failed Zone 6. In addition, the document did not show if the facility followed up to re-adjust the entrapment Zone 6 to reduce the risk of entrapment. Further review of Resident 32's medical record did not show if the facility followed up to re-adjust the entrapment Zone 6 to reduce the risk of entrapment for Resident 32. On 4/4/24 at 1346 hours, an interview and concurrent medical record review for Resident 32 was conducted with the Administrator. The Administrator verified Resident 32's bed (Bed#15) failed on the entrapment Zone 6. The Administrator stated Resident 32's bed failing Zone 6 meant there was a risk Resident 32's head might get entrapped in that zone. On 4/4/24 at 1604 hours, a follow up interview was conducted with the Administrator. The Administrator verified he did not follow up when Bed #15 failed in the entrapment Zone 6. The Administrator added he did not think the siderails could be re-adjusted and he had to buy a new bed. The Administrator further stated he would have the maintenance check the bed to see if he could readjust the Bed #15. On 4/4/24 at 1626 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F552, example #2 47474 2. Review of facility's document titled Side Rail Order undated, showed Resident 9 with left 1/2 (half) SR (Side Rail) Padded. Review of facility's document titled Bed Inspection (Measurement) dated 1/3/24 showed Bed Number 27 was assigned to Resident 9 and showed failed on Zone 6 measurement. Further review of Resident 9's medical record showed the resident had consent for padded left side rail dated 9/14/23. On 4/2/24 at 0842 hours, an initial tour of the facility was conducted. Resident 9 was observed in bed with padded left side rail. Resident 9 was observed able to move the upper extremities. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 9 was initiated on 4/2/24. Resident 9 was admitted to the facility on [DATE] and readmitted back to the facility on [DATE]. On 4/4/24 at 1602 hours, a concurrent interview and facility document review with the Administrator was conducted. The Administrator verified Resident 9's side rail had failed Zone 6 measurement as documented on the facility document titled Bed Inspection (Measurement) dated 1/3/24. When asked if an intervention was conducted on the failed Zone 6 measurement, the Administrator stated the facility did not perform further interventions after a failed Zone 6 measurement for Resident 9's side rails was observed. The Administrator further stated he did not notify the maintenance staff or ask maintenance to reassess the failed Zone 6 measurement and side rails. Moreover, the Administrator stated the facility would have to replace Resident 9's bed frame to ensure Zone 6 measurement did not fail. On 4/5/24 at 1550 hours, an interview with the DON was conducted. The DON acknowledged the above findings. Cross reference to F552 for example #1.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. 47474 Based on observation and interview, the facility failed to ensure Room A did not accommodate more than four residents. At the time of survey, there were five occupied beds in the room, which posed the risk of five residents sharing one room. Findings: On 4/2/24 at 0904 hours, an initial tour of the Room A was conducted. Observation of Room A showed a five-bed room occupied by five residents. On 4/4/24 at 1542 hours, an interview was conducted with the Administrator. The Administrator verified there were five residents occupied in Room A. The Administrator acknowledged Room A had less square footage than required. The Administrator further stated the facility would like to continue with the room variance waiver for Room A. Cross reference to F912.

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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. 47474 Based on observation and interview, the facility failed to ensure Room A measured at least 80 square feet per resident. Room A was a five-bed room, which measured 78.4 feet per resident if all the beds were filled. At the time of the survey, the room was occupied by five residents. This failure to have the designated square footage created the potential to negatively impact the residents' quality of life. Findings: On 4/2/24 at 0904 hours, an initial tour of the Room A was conducted. Observation of Room A showed a five-bed room occupied by five residents. On 4/4/24 at 1542 hours, an interview was conducted with the Administrator. The Administrator stated Room A had a total of 392 square feet and when occupied by five residents, each resident would have 78.4 square foot of space. The Administrator acknowledged the residents should have 80 square foot of space and verified the residents in Room A did not. The Administrator verbalized the facility would like to continue with the room variance waiver for Room A. Cross reference to F911.