STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055742	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Villa Care Center	861 S. Harbor Blvd 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 19 final sampled residents (Residents 24 and 394) and one nonsampled resident (Resident 74) were safe to self-administer the medications found at bedside. * Resident 394 was observed with a bottle of dorzolamide (medication used to treat glaucoma) eyedrops at bedside. Resident 394 stated she administered the eyedrops herself. Resident 394 did not have the assessment and physician's order addressing the resident's self-administration of medication. * Resident 74 was observed with a medication cup containing a gabapentin (anticonvulsant medication) capsule at bedside. Resident 74 stated the charge nurse left the medication for her to self-administer the medication later. Resident 74 did not have the assessment, and physician's order addressing the resident's self-administration of medication. * Resident 24 was observed to have a Vicks VapoRub (cough suppressant and topical analgesic) ointment at the bedside table and had self-administered the medication. These failures had the potential for the residents to administer the medications inaccurately, and the risk of adverse reactions from the medications. Findings: 1. Review of the facility's P&P titled Medication - Self-Administration revised 2/2021 showed the following: - Residents who are identified as being able to self-administer medications are asked whether they wish to do so; - For self-administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken; and - Any medications found at bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 0855 hours, during the initial tour of the facility, Resident 394 was observed sitting in a wheelchair near her bed, and a bottle of dorzolamide eyedrop was observed on the resident's bedside table. Resident 394 stated the charge nurse gave the bottle of eyedrops to her, and she administered one drop to each eye. On 1/7/25 at 0916 hours, an observation for Resident 394 and concurrent interview was conducted with LVN 3. Resident 394 was observed sitting in a wheelchair near her bed, and a bottle of dorzolamide eyedrop was observed on the resident's bedside table. LVN 3 verified the above findings. Medical record review for Resident 394 was initiated on 1/7/25. Resident 394 was admitted to the facility on [DATE]. Review of Resident 394's H&P evaluation dated 12/19/24, showed Resident 394 had the capacity to make decisions. Review of Resident 394's Admission/ Readmission Data Tool V2 - V4 dated 12/18/24, showed Resident 394 did not want to self-administer her medications. Review of Resident 394's Order Summary Report for January 2025 did not show the physician's orders to administer the dorzolamide eyedrops and for Resident 394 to self-administer the dorzolamide medication. On 1/10/25 at 0959 hours, an interview and concurrent medical record review for Resident 394 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated the residents were assessed upon admission whether they wanted to and could self-administer any medications. RN 2 stated if a resident wanted to self-administer medications, then a full assessment was conducted to determine whether the resident could self-administer medications safely. RN 2 verified Resident 394 did not have the physician's orders for the administration of dorzolamide and to self-administer any medications, and Resident 394 was not assessed if she was safe to self-administers medications. 2. On 1/7/25 at 0907 hours, during the initial tour of the facility, Resident 74 was observed in bed, and a medication cup with a capsule was observed on top of the nightstand. When asked what kind of medication was in the medication cup, Resident 74 stated it was for spasms. Resident 74 stated the nurse gave the medication to her so she could take it later. Medical record review for Resident 74 was initiated on 1/7/25. Resident 74 was admitted to the facility on [DATE]. Review of Resident 74's H&P evaluation dated 11/27/24, showed Resident 74 was competent and able to make decisions. Review of Resident 74's Admission/ Readmission Data Tool V2 - V4 dated 11/25/24, showed Resident 74 did not want to self-administer her medications. Review of Resident 74's Order Summary Report for January 2025 showed a physician's order dated 11/25/24, to administer gabapentin 300 mg by mouth every eight hours for neuropathy. Further review of Resident 74's Order Summary Report did not show a physician's order to self-administer the gabapentin medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 0913 hours, an interview and concurrent medical record review for Resident 74 was conducted with LVN 3. Resident 74 was observed in bed, and a medication cup with a capsule was observed on top of the nightstand. LVN 3 verified the above findings. LVN 3 stated it was a gabapentin capsule in the medication cup. LVN 3 stated Resident 74 could physically take the gabapentin medication herself, however, she was not assessed if she could self-administer medications safely, and there was no physician's order for Resident 74 to self-administer medications. 49644 3. On 1/7/25 at 0841 hours, during the initial tour of the facility, a Vicks VapoRub (cough suppressant and topical analgesic) ointment was observed on top of Resident 24's bedside table. Resident 24 stated she applied the Vicks VapoRub ointment on her nose. Medical record review for Resident 24 was initiated on 1/7/25. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's MDS dated [DATE], showed Resident 24 was cognitively intact. Review of Resident 24's Order Summary Report for January 2025 did not show the physician's orders to administer the Vicks VapoRub ointment and for Resident 24 to self-administer the Vicks VapoRub ointment. On 1/7/25 at 1023 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the Vicks VapoRub ointment on top of Resident 24's bedside table. LVN 1 further verified there was no physician's order for Resident 24 to have the Vicks VapoRub ointment at bedside. LVN 1 stated he would notify the physician and get an order for Vicks VapoRub ointment so Resident 24 could self-administer the Vicks VapoRub ointment. On 1/10/25 at 1631 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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** 39453 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the needs for two of 29 final sampled residents (Residents 5 and 48) and four nonsampled residents (Residents 9, 29, 35, and 38). * The facility failed to ensure the call lights were within reach and accessible for Residents 5, 9, 29, 35, 38, and 83. This failure had the potential to result in a delay in the provision of care and the potential to negatively impact the residents' psychosocial well-being. Findings: Review of the facility's P&P titled Answering the Call Lights (undated) showed the purpose of this procedure is to ensure timely responses to the resident's requests and needs, and to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and from the floor. 1. On 1/7/25 at 0837 hours, Resident 9 was observed in bed, yelling, and pointing to the window. The call light was observed clipped on the right side of the bed, near the headboard and was not within Resident 9's reach. On 1/7/25 at 0842 hours, an observation for Resident 9 and concurrent interview was conducted with CNA 6. Resident 9 was observed in bed, yelling, and pointing to the window. The call light was observed clipped on the right side of the bed, near the headboard and was not within Resident 9's reach. CNA 6 verified the above findings. CNA 6 stated Resident 9 could use the call light. Medical record review for Resident 9 was initiated on 1/7/25. Resident 9 was readmitted to the facility on [DATE]. Review of Resident 9's MDS dated [DATE], showed Resident 9 required substantial/ maximal assistance with bed mobility. 2. On 1/8/25 at 1101 hours, during the Resident Council meeting, the residents were asked regarding the call light being placed within reach. Resident 38 stated she often could not reach her call light when she was in bed. Resident 38 stated she would ask her roommate to push her call light for her so she could ask the facility staff for assistance. Resident 38 stated this happened in any shift. Medical record review for Resident 38 was initiated on 1/7/25. Resident 38 was readmitted to the facility on [DATE]. Review of Resident 38's MDS dated [DATE], showed Resident 38 was cognitively intact, and required partial/ moderate assistance with bed mobility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 1/8/25 at 1101 hours, during the Resident Council meeting, the residents were asked regarding the call light being placed within reach. Resident 29 stated her call light was sometimes not within reach, and she asked her roommate to push her call light for her so she could ask the facility staff for assistance. Medical record review for Resident 29 was initiated on 1/7/25. Resident 29 was readmitted to the facility on [DATE]. Review of Resident 38's MDS dated [DATE], showed Resident 38 was cognitively intact, and required substantial/ maximal assistance with bed mobility. 4. On 1/8/25 at 1101 hours, during the Resident Council meeting, the residents were asked regarding the call light being placed within reach. Resident 5 stated her call light was sometimes not within reach and she yelled for help to ask for assistance from the facility staff. Medical record review for Resident 5 was initiated on 1/7/25. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's MDS dated [DATE], showed Resident 5 was cognitively intact, and required substantial/ maximal assistance with bed mobility. 5. On 1/8/25 at 1101 hours, during the Resident Council meeting, the residents were asked regarding the call light being placed within reach. Resident 35 stated when the CNAs provided her incontinence care, they would forget to clip her call light within her reach. Resident 35 stated she just waited for someone to come to her room, so she could ask for assistance. Medical record review for Resident 35 was initiated on 1/7/25. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's MDS dated [DATE], showed Resident 35 was cognitively intact and required partial/ moderate assistance with bed mobility. On 1/10/25 at 1530 hours, an interview was conducted with the DSD. When asked about the residents' call light, the DSD stated when the resident was in the room, whether in bed or wheelchair, the call light should be within the resident's reach at all times. 48332 6. On 1/7/25 at 1026 hours, an observation was conducted for Resident 48. Resident 48 was observed lying in bed with the call light hanging on the wheelchair, away from Resident 48. Medical record review for Resident 48 was initiated on 1/7/25. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's MDS dated [DATE], showed Resident 48 had no impairment with the use of his upper extremities and was independent on the use of the manual wheelchair. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 1035 hours, an observation and concurrent interview was conducted with CNA 2 for Resident 48. CNA 2 verified the call light was hanging on Resident 48's wheelchair, and not within Resident 48's reach. CNA 2 stated the call light should be on the resident's bed and close to the resident so he could call for help if he needed. Resident 48 was able to move his upper extremities and wheel himself on the wheelchair.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 39453 Based on interview, facility document review and facility P&P review, the facility failed to respond to the concerns brought up by the residents during the Resident Council meetings. * The facility failed to show what facility administrative actions were taken to address the concerns from the Residents Council meetings on 7/11, 9/12, and 10/10/24, regarding the medications, snacks, and CNA interactions with the residents. This failure had the potential for the residents' identified issues to not be resolved, a delay in the provision of care, and a decline in quality of life for the residents. Findings: Review of the facility's P&P titled Grievances Complaint, Filing revised 4/2017 showed the following: - The Administrator and the staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative; - All grievances, complaints or recommendation stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response; and - Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five working days of receiving the grievance and/or complaint. a. Review of the Resident Council Agenda/ Minutes dated 7/11/24, under the Nursing Services section, showed a resident stated not getting her pain medication on time. There was no documentation to show this concern was addressed by the nursing department. b. Review of the Resident Council Minutes dated 9/12/24, under the Nursing section, showed the residents were not happy with the medications not being ordered on time. There were times when they don't have all their meds. In addition, under the Dietary section, the residents would just like to have more snacks. Review of the Resident Council Departmental Response Form for the meeting dated 9/12/24, under the Department Response to Resident Council section, showed a handwritten note which was not legible. There was no documentation to show the dietary concern was addressed by the dietary department. c. Review of the Resident Council Minutes dated 10/10/24, under the Nursing section, showed the resident expressed sometimes the CNAs talk to them in a childish tone or as if they were close as family, and they are not always in the mood for that type of interaction. There was no documentation to show this concern was addressed by the nursing department. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 1201 hours, a concurrent interview and facility document review was conducted with the Activities Director and Activities Staff. The Activities Director and Activities Staff verified the above findings. The Activities Staff stated they used the Resident Council Departmental Response Form to show the concerns by the resident council, and the response by the department to which the resident council had concerns with. The Activities Staff stated the resolution of the resident council concerns would be discussed in the next resident council meeting. The Activities Staff stated the previous Activities Director coordinated the resident council meeting, and without the response form she would not be able to show what facility administrative actions were taken to address the resident council concerns and if the resident council concerns were resolved. On 1/8/25 at 1611 hours, a concurrent interview and facility document review was conducted with the DON. When asked if the nursing department was made aware of the concerns from the resident council meeting dated 7/11/24, regarding a resident not getting pain medication, the DON stated he was not made aware about this concern, and he did not get a response form from the Activities Director. When asked if the nursing department was made aware of the concerns from the resident council meeting dated 9/11/24, regarding residents' medications not being ordered on time and not having all of the residents' medications, the DON stated the Activities Staff gave him the response form today (1/8/25), and the DON stated he wrote the department response on the form. When asked what was documented as the nursing department's response to concerns from the resident council meeting dated 9/11/24, the DON was not able to read his handwriting. When asked if the nursing department was made aware of the concerns from the resident council meeting dated 10/10/24, regarding the CNAs talking to the residents in a childish tone, the DON stated he was not informed of this concern. On 1/8/25 at 1643 hours, a concurrent interview and facility document review was conducted with the DSD. When asked if the nursing department was made aware of the concerns from the resident council meeting dated 10/10/24, regarding the CNAs talking to the residents in a childish tone, the DSD stated she was not informed of this concern. On 1/9/25 at 1430 hours, a concurrent interview and facility document review was conducted with the CDM. When asked if the dietary department was made aware of the concerns by the resident council meeting dated 9/12/24, regarding the residents wanting more snacks, the CDM stated she was not informed of this concern.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50787 Based on observation, interview, and medical record review the facility failed to provide the clean, sanitary, and homelike environment for one of 19 final sampled residents (Resident 64). This failure had the potential to negatively impact the resident's well-being. Findings: On at 1/8/25 at 0918 hours, during the initial tour of the facility, the wall by Resident 64's head of bed was observed to have scattered chipped paint. On 1/9/25 at 0754 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director touched the chipped paint on Resident 64's wall and stated, I have not seen this before. The Maintenance Director acknowledged the findings. On 1/9/25 at 0807 hours, an observation and concurrent interview was conducted with CNA 5. When ask about the chipped paint on Resident 64's wall, CNA 5 stated it's been there for a week, but I always forget to report it, my focus was on the resident. CNA 5 verified the above findings. On 1/10/25 at 1501 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0625 Level of Harm - Potential for minimal 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** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to notify one of two residents (final sampled resident, Resident 44) reviewed for hospitalization of their right 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 Resident 44 and/or his representative to be unaware of their rights to request a bed hold upon transfer. Findings: Review of the facility's P&P titled Bed Holds and Returns revised 10/2022 showed the residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. The Policy Interpretation and Implementation section showed: - All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. Notice I: well in advance of any transfer (e.g., in the admission packet); and b. Notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). Medical record review for Resident 44 was initiated on 1/7/25. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 44's H&P examiniation dated 10/20/24, showed Resident 44 was not competent and not able to enter into a contract, including the admission agreement. Review of Resident 44's eINTERACT Transfer Form V5 dated 10/12/24, showed Resident 44 was transferred to the acute care hospital. Review of Resident 44's medical record failed to show documented evidence Resident 44's representative was notified of the bed hold provision when the resident was transferred to the acute care hospital on 10/12/24. On 1/7/25 at 1029 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified there was no documentation to show Resident 44's responsible party was informed of the bed hold. LVN 1 stated Resident 44's responsible party should have been informed of the bed hold so they would know Resident 44 could come back to the facility within seven days. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	On 1/9/25 at 1410 hours, an interview and concurrent medical record review was conducted with the Admissions Coordinator. The Admissions Coordinator verified Resident 44 had no bed hold notification when he transferred to the acute care hospital. The Admissions Coordinator stated there was no documentation for the bed hold notification on the resident's medical record when Resident 44 was transferred to the acute care hospital on 10/12/24. On 1/10/25 at 1631 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on interview, medical record review, and facility document review, the facility failed to ensure the PASARR (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) Level 1 assessment was coded accurately for one of three final sampled residents reviewed for PASARR (Resident 52). This failure had the potential for having residents that were not appropriate in the facility and for Resident 52 not to receive the appropriate services. Findings: Medical record review for Resident 52 was initiated on 1/7/25. Resident 52 was admitted to the facility on [DATE]. Review of Resident 52's PASARR Level 1 Screening Form dated 6/21/24, showed Resident 52 had no prescribed psychotropic medications for mental illness. However, review of Resident 52's Order Summary Report dated 1/9/25, showed Resident 52 had the physician's orders dated 6/21/24, to administer Zyprexa (antipsychotic medication) 5 mg by mouth two times a day for agitation, and lorazepam (anti-anxiety medication) 0.5 mg one tablet by mouth two times a day for anxiety (mental health condition involving repeated episodes of sudden feelings of fear, dread and uneasiness). Review of Resident 52's Admission Record dated 1/9/25, showed Resident 52 had diagnoses which included major depressive disorder (persistent low mood and loss of interest in activities), bipolar disorder (mood disorder), and anxiety. On 1/9/25 at 0830 hours, an interview and concurrent medical record review for Resident 52 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated there was an error in completing the PASARR Level 1 assessment for Resident 52. The MDS Coordinator further stated if the PASARR Level 1 was not accurately completed, the facility must do the screening again and refer accordingly. The MDS Coordinator verified Resident 52 had diagnoses of major depressive disorder, bipolar disorder (mood disorder), and anxiety and had been receiving psychotropic medication. The MDS Coordinator stated Resident 52's PASARR Level 1 was not completed accurately. On 1/9/25 at 1445 hours, an interview and medical record review for Resident 52 was conducted with the DON. The DON was informed and verified the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to develop the comprehensive person-centered care plan for one of 19 final sampled residents (Resident 75). This failure had the potential to negatively impact the health of the resident. Findings: Review of the facility's P&P titled Care Plans - Baseline revised 3/2022 showed the baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident. Medical record review for Resident 75 was initiated on 1/7/25. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's MDS dated [DATE], showed Resident 75 was cognitively intact. Review of Resident 75's Order Summary Report for January 2025 showed a physician's order dated 11/22/24, for FC FR #16/30 cc to BSD due to diagnosis of urinary retention (difficulty urinating and completely emptying the bladder) and obstructive uropathy (a condition in which the flow of urine is blocked) every shift. Review of Resident 75's plan of care failed to show a care plan was developed to address Resident 75's use of indwelling urinary drainage catheter. On 1/9/25 at 1046 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified there was no care plan for Resident 75's indwelling urinary drainage catheter use. LVN 1 stated Resident 75's care plan should have been inititated by the licensed nurse to make sure there was no complication with Resident 75's indwelling urinary drainage catheter. On 1/10/25 at 1631 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, and facility document review, the facility failed to provide the individualized and ongoing activity program to meet the needs and interests for two of 19 final sampled residents (Residents 5 and 22) and two nonsampled residents (Residents 9 and 35). * The facility failed to provide the activities for Residents 9 and 22 which met the residents' identified interests. * The facility failed to ensure the bingo game was not cut-off by the activity department to supervise the smokers as per the concerns of Residents 5 and 35. These failures had the potential for the residents to experience feelings of social isolation and depression. Findings: Review of the facility's P&P titled Activity Programs revised 6/2018 showed the following: - Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident; - The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities; - All activities are documented in the resident's medical record; - Individualized and group activities are provided that reflect schedules, choices, and rights of the residents; and are offered at hours convenient to the residents, including evenings, holidays and weekends; and - Adequate space and equipment are provided to ensure that needed services identified in the resident's plan of care are met. 1. On 1/7/25 at 1007 hours, during the initial tour of the facility, Resident 9 was observed in the activities room watching TV, in English language. On 1/8/25 at 1627 hours, Resident 9 was observed lying awake in bed. There was no television provided for Resident 9. Resident 9's roommate's TV was on but in a foreign language other than Resident 9's preferred language. On 1/8/25 at 1628 hours, an observation and concurrent interview for Resident 9 was conducted with CNA 7. Resident 9 was observed awake in bed and was watching her roommate's TV which was turned on, in a foreign language, other than Resident 9's preferred language. CNA 7 verified the above findings. CNA 7 stated Resident 9 did not speak or understand her roommate's preferred language. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 22 was initiated on 1/7/25. Resident 22 was readmitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 3/18/24, showed Resident 22 had no capacity to make medical decisions. Review of Resident 22's plan of care showed a care plan problem dated 8/7/24, to address Resident 22's continued preference to attend and participate in group activities in the morning, and some occasional afternoon activities as tolerated or as desired, and Resident 22 knew very limited English, and this language may affect her time in the activities. The interventions included to offer 1:1 (one resident to one staff member) enrichment programming in the room when not attending group activities. Review of Resident 22's Activity Participation Review dated 11/7/24, showed Resident 22's activity preferences included arts/ crafts, exercises, and watching TV/ movies. Further review of Resident 22's medical record showed a care plan problem dated 11/18/24, to address Resident 22's communication problem related to Resident 22's preferred language. The interventions included to provide a program of activities that accommodates the resident's communication abilities. On 1/9/25 at 1519 hours, Resident 22 was observed in bed, awake and watching her roommate's TV, in another foreign language, and not in Resident 22's preferred language. There was no TV provided for Resident 22. When asked if she understood her roommate's TV in another foreign language, Resident 22 stated she wanted to watch TV in her preferred language. On 1/10/25 at 1549 hours, an interview and concurrent medical record review and facility document review for Resident 22 was conducted with the Activities Director and Activities Staff. The Activities Staff stated Resident 22 had another preferred language but understood English. When asked regarding Resident 22's activities, the Activities Staff stated Resident 22 participated in group activities such as coffee social, exercise, and music, to which she showed Resident 22's Activity Participation Records. Review of Resident 22's Activity Participation Records for December 2024, showed Resident 22 participated group activities such as coffee social, exercise, and music daily. Review of Resident 22's Activity Participation Records for January 2025 was blank and did not show any documentation Resident 22 attended any activities. The Activities Director and Activities Staff verified the above findings. On 1/10/25 at 1555 hours, an observation and concurrent interview for Resident 22 was conducted with the Activities Director. Resident 22 was observed in bed, awake and watching her roommate's TV, in another foreign language, and not in Resident 22's preferred language. There was no TV provided for Resident 22. When asked if she understood her roommate's TV in another foreign language, Resident 22 stated she wanted to watch TV in her preferred language. The Activities Director verified the above findings. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 1/8/25 at 1101 hours, during the Resident Council meeting, when asked what other concerns the Resident Council wanted to discuss, Resident 35 stated their Bingo game used to start at 1430 hours but was changed to 1400 hours. Resident 35 stated the activities department had to stop their Bingo game at 1500 hours because the other residents needed to smoke. Medical record review for Resident 35 was initiated on 1/7/25. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 1/2/24, showed Resident 35 was competent and able to make decision. Review of Resident 35's Activity Participation Review dated 12/23/24, showed Resident 35's activity preferences included arts/ crafts, cards/ table games, computer/ internet, discussions/ reminiscence, exercise/ sports, resident council, watching TV/ movies, and word games/ puzzles. Review of Resident 35's Activity Attendance Record for December 2024, showed Resident 35 attended the Bingo game on 12/6, 12/7, 12/8, 12/13, 12/14, 12/15, 12/20, 12/21, 12/22, 12/27, 12/28, and 12/29/24. Review of Resident 35's Activity Attendance Record for January 2025 showed Resident 35 attended the Bingo game on 1/3, 1/4, and 1/7/25. 4. On 1/8/25 at 1101 hours, during the Resident Council meeting, when asked what other concerns the Resident Council wanted to discuss, Resident 5 stated the activity department had to cut their time with the activities, especially the Bingo game, because the activity staff had to supervise the residents who smoked. Medical record review for Resident 5 was initiated on 1/7/25. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 11/20/24, showed Resident 5 was competent and able to make decision. Review of Resident 5's Activity Participation Review dated 1/4/25, showed Resident 5's activity preferences included arts/ crafts, cards/ table games, discussions/ reminiscence, exercise/ sports, resident council, watching TV/ movies, and word games/ puzzles. Review of Resident 5's Activity Attendance Record for December 2024, showed Resident 5 attended the Bingo game on 12/8, 12/9, 12/14, 12/15, 12/21, 12/28, and 12/29/24. Review of Resident 5's Activity Attendance Record for January 2025, showed Resident 5 attended the Bingo game on 1/4/25. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 1201 hours, an interview and concurrent facility document review was conducted with the Activities Director and Activities Staff. When asked about the Bingo game for the residents, the Activities Staff stated the Bingo game was from 1400 to 1520 hours, every Fridays, Saturdays, and Sundays. When asked if they had to cut off the Bingo game so the activity staff could supervise the residents who smoked, the Activities Staff stated they were not stopping in the middle of the Bingo game, and they made sure the Bingo game was done, but they had told the residents that it was a smoke break at 1530 hours. The Activities Director stated the Bingo game was usually for one hour and a half, so the residents had plenty of time. When asked why it had to be stopped at 1520 hours, the Activities Staff stated they had to prepare and assist the residents who smoked to the patio, provide the smoking apron, and give and light their cigarettes. The Activities Staff stated it was usually the activities department who had to supervise the residents who smoked every two hours, at 1330 hours on Mondays to Thursdays, at 1530 hours on Fridays, and at 1030, 1330, and 1530 hours on Saturdays and Sundays, which coincided with the residents' Bingo game. The Activities Staff showed a copy of the Activity Calendar and Smoking Supervisor Schedule. Review of the Activity Calendar for January 2025 showed the Bingo game was at 1400 hours on Fridays, Saturdays, and Sundays. Review of the Smoking Supervisor Schedule showed the Activities department was to supervise the residents who smoked on Fridays at 1530 hours, and on Saturdays and Sundays at 1330 and 1530 hours. The Activities Director and Activities Staff verified the above findings. On 1/10/25 at 0836 hours, an interview was conducted with the Activities Assistant. The Activities Assistant stated the Bingo game for the residents were scheduled on every Friday, Saturday, and Sunday from 1400 hours to 1530 hours. The Activities Assistant stated on Fridays, the other department supervised the residents who smoke and did not have any issue; however, on the weekends (Saturday and Sunday), the activity department was assigned to monitor the residents who smoked. The Activities Assistant stated she could not remember the exact dates, but when she worked on the weekends, there were times she had to start the Bingo game late for about 10 to 15 minutes because she had to supervise the residents who smoked. The Activities Assistant further stated the residents who wanted to play Bingo on time would get upset. The Activities Assistant stated she brought up the issue to the Activities Director but nothing had been done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, medical record review, and facility document review, the facility failed to ensure one of 19 final sampled residents (Resident 64) was provided with the prescribed liquid consistency diet per the physician's order. This failure had the potential to negatively affect Resident 64's health condition and well- being. Findings: On 1/7/25 at 0901 hours, during initial tour to the facility, a cup of thin clear liquid with a straw and a pitcher labeled with Resident 64's name and room number, Nectar, and dated 12/30/24 was observed on Resident 64's bedside table. CNA 5 was observed entering Resident 64's room and verified both the cup with thin liquid and the pitcher labeled Nectar was on Resident 64's bedside table. CNA 5 was then observed removing the cup with the thin liquid from the resident's bedside table. CNA 5 stated the thickened liquid with the nectar consistency was being given to the resident and proceeded to point at the pitcher labeled as Nectar. CNA 5 then opened the pitcher cover to show the nectar thickened liquid inside. On 1/8/25 at 1302 hours, Resident 64 was observed out of bed, sitting on the wheelchair and eating lunch at the bedside. Resident 64's meal ticket showed the following diet order: RCS (reduced concentrated sweets-smaller portion of dessert and served with sugar substitute packets) diet; minced and moist texture 5 (soft and easy to form into a ball); thin liquid consistency; and fluid restriction. On 1/8/25 at 1308 hours, an interview was conducted with the Speech Therapist. When asked about Resident 64's liquid consistency order, the Speech Therapist stated Resident 64's liquid consistency order was changed from nectar consistency to thin liquid consistency. On 1/8/25 at 1404 hours, an interview was conducted with the Speech Therapist, COTA (Certified Occupational Therapy Assistant) and CDM (Certified Dietary Manager). The CDM stated the following was the process of providing thickened liquids to the residents: - the thickened water pitcher was removed from the resident's bedside by the CNA from the night shift. - the kitchen staff would pick up the pitchers around 0500 hours and replace them with a fresh thickened water pitcher labeled with the resident's name, room number, specific liquid consistency ordered and the current date. Medical record review of Resident 64 was initiated on 01/9/25. Resident was initially admitted on [DATE], and readmitted on [DATE]. Review of Resident 64's plan of care showed a care plan problem dated 11/21/24, addressing the resident's risk of aspiration due to decline in swallowing. The risk of aspiration care plan showed Resident 64 had nectar thickened liquid consistency order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 64's MDS dated [DATE], showed Resident 64 had a BIMS score of six, which indicated severe cognitive impairment. Review of Resident 64's Speech Therapy Treatment Encounter Note dated 1/2/25, showed Resident 64's liquid consistency order was changed to thin liquid. Review of Resident 64's Order Summary Report dated 1/9/25, showed a physician's order dated 1/2/25, to change Resident 64's liquid consistency order from nectar thickened liquid to thin consistency. Further review of the resident's medical record showed Resident 64's care plan was not revised to reflect the change from nectar to thin liquid consistency as per the physician's order on 1/2/25. On 1/10/25 0926 hours, interview was conducted with the DON. The DON verified Resident 64's liquid consistency order was changed from nectar to liquid consistency. On 1/10/25 1520 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the 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** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for two of 19 final sampled residents (Residents 44 and 20) and two nonsampled residents (Residents 97 and 99) reviewed for respiratory care. * The facility failed to ensure Resident 44's nasal cannula was applied properly. * The facility failed to ensure the oxygen cannula for Resident 97 was stored in a set-up bag when not in use, and ensure a physician's order was obtained prior to administering oxygen to the resident. In addition, the facility failed to ensure a No Smoking/Oxygen in Use sign was posted outside the resident's door per the facility's P&P. * The facility failed to ensure the nebulizer mask and canister for Resident 99 was stored in a set-up bag when not in use. * The facility failed to ensure Resident 20's nebulizer mask and canister was stored in a sanitary manner. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: 1. Review of the facility's P&P titled Oxygen Administration dated 10/2010 showed the purpose of this procedure is to provide guidelines for safe oxygen administration. The General Guidelines section showed the nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. Medical record review for Resident 44 was initiated on 1/7/25. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 44's medical record showed the resident's diagnoses included hypoxemia (low oxygen in the blood). Review of Resident 44's Order Summary Report showed a physician's order dated 10/19/24, to administer the oxygen at two liters per minute via nasal cannula continuously every shift. On 1/7/25 at 1006 hours, an observation and concurrent interview was conducted with LVN 1. Resident 44's nasal cannula was observed on her face but the nasal cannula's nasal prongs were not in Resident 44's nose. Resident 44's oxygen was on at two liters per minute and connected to the oxygen concentrator. LVN 1 verified the nasal cannula was on Resident 44's face and the nasal cannula's nasal prongs were not in Resident 44's nose. LVN 1 was then observed putting the nasal cannula's nasal prongs into Resident 44's nose and checked Resident 44's oxygen saturation. Resident 44's saturation was 97%. LVN 1 stated the nasal cannula's nasal prongs should have been in Resident 44's nose so the oxygen saturation level would be within range. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 1631 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39453 2. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed the following: -To verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration; and -The following equipment and supplies will be necessary when performing this procedure, included, No Smoking/ Oxygen in Use signs. On 1/7/25 at 0930 hours, during the initial tour of the facility, Resident 97 was observed awake, and in bed. A nasal cannula, connected to the oxygen concentrator, was observed on the floor. Resident 97 stated he was administered with oxygen at night. A No Smoking/Oxygen in Use sign was not posted at the door of Resident 97's room. Medical record review for Resident 97 was initiated on 1/7/25. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's Order Summary Report dated 1/8/25, did not show a physician's order to administer the oxygen. On 1/7/25 at 1018 hours, an observation for Resident 97 and concurrent interview and medical review was conducted with LVN 5. The nasal cannula for Resident 97 was observed on the floor, and was not stored in a clean set-up bag. LVN 5 verified the above findings. LVN 5 also verified the No Smoking/Oxygen in Use sign was not posted at the door for Resident 97 nor to the rooms of other residents using oxygen. 3. On 1/7/25 at 0919 hours, during the initial tour of the facility, a nebulizer mask with canister and tubing, connected to the nebulizer machine, was observed inside a reusable shopping bag. Medical record review for Resident 99 was initiated on 1/7/25. Resident 99 was admitted to the facility on [DATE]. Review of Resident 99's Order Summary Report dated 1/8/25, showed a physician's order to administer ipratropium-albuterol inhalation solution (a combination of anticholinergic and bronchodilator medications) 0. 5-2.5 three ml every six hours. On 1/7/25 at 1016 hours, an observation for Resident 99 and concurrent interview and medical review was conducted with LVN 5. Resident 99 was observed awake in bed. The nebulizer mask with canister and tubing, connected to the nebulizer machine, was observed inside a reusable shopping bag. LVN 5 verified the above findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 1411 hours, an interview was conducted with the Central Supply Staff. The Central Supply Staff stated he was responsible for changing the nasal cannula tubing, humidifier, and nebulizer mask with canister and tubing, and the set-up bag every Wednesday, and as necessary. The Central Supply Staff stated the No Smoking/Oxygen in Use sign should be posted outside the door of the residents who used oxygen. The Central Supply Staff stated the licensed nurses could also change the respiratory tubing, equipment, and bag, and post the No Smoking/Oxygen in Use sign outside the door of the residents who used oxygen because they also have access to the central supply room. 44175 4. On 1/7/25 at 0919 hours, Resident 20 was observed laying in bed, a nebulizer mask with canister was observed on the nightstand located on the left side of the Resident 20's bed and not stored in a clean set-up bag. On 1/7/25 at 0942 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified the above findings and stated the nebulizer mask with the canister should have been stored in a clean set up bag to prevent environmental contamination. RN 1 then stated she would replace the nebulizer mask and tubing for Resident 20. On 1/9/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and 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** 39453 Based on interview, medical record review, and facility P&P review, the facility failed to accurately monitor the fluid intake and output for one final sampled resident (Resident 394) reviewed for hemodialysis care. This failure had the potential for Resident 394 to experience life threatening conditions associated with fluid deficit/overload. Findings: Review of the facility's P&P titled Intake and Output, Monitoring revised 1/2024 showed the following: - It is the policy of the facility to ensure the intake and output is monitored and accurately documented when it is ordered by the resident's physician or implemented by the licensed nurse or IDT to evaluate hydration, fluid restrictions, or assist in assessment and management of fluid needs; - Nursing personnel are responsible for recording on the Intake and Output Record as appropriate for each resident under their care; and - Nursing personnel are responsible are responsible to add intake and output amounts to the UDA Task throughout their shift. Other staff involved in providing liquids such as Activity Department will report amounts taken by the resident to nursing personnel to include in the UDA task. Medical record review for Resident 394 was initiated on 1/7/25. Resident 394 was admitted to the facility on [DATE]. Review of Resident 394's Order Summary Report dated 1/10/25, showed the following physician's orders: - dated 12/29/24, to arrange dialysis every Tuesdays, Thursdays, and Saturdays; and - dated 12/29/24, to monitor intake and output for fluid restriction of 1000 ml daily. The fluid intake limit for nursing was 400 ml, which was broken down to 200 ml for 0700 to 1500 hours shift, 100 ml for 1500 to 2300 hours shift, and 100 ml for 2300 to 0700 hours shift. The fluid intake limit for dietary was 600 ml, which was broken down to 240 ml for breakfast, 120 ml for lunch, and 240 ml for dinner. Review of Resident 394's MAR for December 2024 and January 2025 showed an average of 500 to 640 ml fluid intake daily, and an average of three outputs daily. Resident 394's output was documented as x1 per shift. Further review of Resident 394's medical records did not show other documentation of Resident 394's daily fluid intake and output. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 0959 hours, a concurrent interview and medical record review for Resident 394 was conducted with RN 2. When asked about the monitoring of Resident 394's fluid intake and output, RN 2 stated the fluid intake and output for the nursing and dietary were documented in the MAR. RN 2 verified Resident 394's average fluid intake was 500 to 640 ml daily, and an average of three outputs daily, as per the MAR. When asked for the weekly monitoring of Resident 394's fluid intake and output, RN 2 stated this was documented in a separate document called the Weekly Intake and Output Evaluation. Review of Resident 394's Weekly Intake and Output Evaluation showed the following: - For the evaluation date 12/29/24, the 24-hour average intake was 1100 ml, and the average output was 1000 ml; and - For the evaluation date 1/5/25, the 24-hour average intake was 1100 ml, and the average output was 100 ml. Review of Resident 394's average daily intake and output in the MAR did not match the documentation in the Weekly Intake and Output Evaluation. RN 2 verified the above findings. When asked about Resident 394's average 24-hour output of 1000 ml documented on 12/29/24, and an average 24-hour output of 100 ml documented on 1/5/25, as per the Weekly Intake and Output Evaluation, RN 2 stated the nursing staff member estimated Resident 394's output based on the incontinent brief changes. RN 2 stated if the pad was soaked, then it would be estimated as 100 ml. When asked about Resident 394's average 24-hour intake of 1100 ml as per the Weekly Intake and Output Evaluation which did not match the documentation of Resident 394's intake and output in the MAR, RN 2 stated the documentation in the MAR was for nursing, and the CNA documented the dietary intake on another record. Review of the POC Response History dated 12/19/24 to 1/8/25, showed documentation of Resident 394's amount of food eaten as 0 to 25%, 26 to 50%, 51 to 75%, and 76 to 100%. There was no documentation of the actual fluid intake amount of Resident 394's dietary intake. In addition, there was no documentation of Resident 394's output. RN 2 verified the above findings. When asked about Resident 394's fluid intake from the dietary, RN 2 stated the nursing staff member estimated the fluid amount based on the percentage of Resident 394's food intake. RN 2 stated if Resident 394's food amount eaten was 76 to 100 %, it would be assumed Resident 394 had consumed 100 % of fluid which would be 120 ml from that meal. RN 2 stated the facility followed the dietary fluid allowance as per the physician's order. RN 2 verified Resident 394's intake and output was assumed and not accurately monitored.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the IP had specific competencies and standard of practice skill sets needed to provide the safe and efficient nursing services to the residents as evidenced by: * The IP failed to identify the six moments of EBP. * The IP failed to document the meeting minutes on the Infection Control Committee Meeting Minutes form. * The IP failed to correctly identify HAI and CAI. * The IP failed to identify what the infection onset date was for. * The IP failed to provide accurate information on the Antibiotic Time Out to Resident 694's physician. * The facility failed to ensure CNA 8 and LVN 6 were competent about EBP. CNA 8 and LVN 6 were not able to identify when to use EBP and were not provided with training on EBP. These failures had the potential to put the residents at risk for services not provided in a safe and competent manner. Findings: Review of the Position Summary section of the IP's job description showed the IP is accountable for decreasing the incidence and transmission of infectious diseases between patients, staff, visitors, and the community. Through strategic planning, leadership, and consultation, you will lead and direct a robust team in the identification and implementation of infection prevention goals and objectives throughout the facility. The IP reports to the Director of Nursing and partners with the Medical Director and Pharmacist for Antimicrobial Stewardship, the QA Committee, and other stakeholders to develop a system of care that promotes sound and scientific infection prevention principles and practices. Review of the facility's P&P titled Staffing, Sufficient, and Competency Nursing revised 8/2022 showed the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Review of the facility's P&P titled Infection Preventionist revised 9/2022 showed the IP is responsible for coordinating the implementation and updating of the infection prevention and control program. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of the facility's P&P titled Enhanced Barrier Precautions revised 8/2022 showed the EBPs are utilized to prevent the spread of MDROs to the residents. Review of the facility's EBP signage document showed everyone must perform hand hygiene before entering the room. Anyone anticipating in any of these six moments must also don gown and gloves. Change and discard gown and gloves and perform hand hygiene between each resident and before leaving room. The EBP six moments were morning and evening care, toileting and changing incontinence briefs, device care or use, wound care, transferring and preparing to leave room, and changing linens. On 1/8/25 at 1101 hours, an interview was conducted with the IP. When the IP was asked about what the six moments of EBP were, the IP was not able to answer the question. On 1/8/25 at 1151 hours, a follow up interview was conducted with the IP. The IP stated she has been asking for more training. The IP further stated she had a total of four days of training for the IP role. The IP stated she did online training but it was different from the actual floor training. 2. Review of the Infection Control Committee Meeting Minutes form dated 11/19/24, showed the form was blank but signed by the IP and the infection control committee members. On 1/8/25 at 1151 hours, a concurrent interview and facility document review was conducted with the IP. The IP verified the Infection Control Committee Meeting Minutes form were signed by the IP and the infection control committee members but there was no documentation of the meeting minutes. On 1/9/25 at 1657 hours, a concurrent interview and facility document review was conducted with the DON. The DON verified the Infection Control Committee Meeting Minutes form was blank. 3. Review of the facility's P&P titled Healthcare-Associated Infections, Identifying revised 9/2017 showed HAIs are those that are acquired during the delivery of healthcare across settings, in contrast to those that were acquired prior to entering the healthcare setting but may persist after admission to the facility. According to the National Library of Medicine, CAIs are defined as infections acquired in the community. On 1/9/25 at 1620 hours, an interview was conducted with the IP. When the IP was asked about what HAIs were, the IP stated Hospital Acquired Infection and the resident contracted the infection at the acute care hospital. When the IP was asked about what CAI was, the IP stated Community Acquired Infection and the resident contracted the infection at the facility three days later after admission. 4. According to the National Library of Medicine, onset date is defined as the date a symptom first appears. On 1/9/25 at 1620 hours, a concurrent interview and facility document review was conducted with the IP. The IP reviewed the infection onset date column of the Infection Prevention and Control Surveillance Log. When the IP was asked about the infection onset date, the IP stated it was the start of the antibiotic. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. On 1/9/25 at 1620 hours, a concurrent interview and medical record review was conducted with the IP. The IP stated the Antibiotic Time Out form showed Resident 694's prescribed antibiotic, the side effects to the antibiotic, and the laboratory tests related to the use of antibiotic. Review of the Resident 694's Antibiotic Time Out form showed Resident 694's physician was notified of suspected adverse reaction related to the antibiotic. When asked which suspected adverse reactions were notified to the physician, the IP stated there were no adverse reactions. The IP stated she made a mistake and did not provide accurate information to the physician. 39453 6. According to CDC, EBP are an infection control intervention designed to reduce the transmission of MDRO in nursing homes. It involves gown and glove use during high-contact resident care activities for residents know to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition such as residents with wounds or indwelling medical devices. Review of the facility's document EBP (undated) showed everyone must clean their hands, including before entering and when leaving the room. It also showed the providers and staff must also wear gloves and gowns for the following high-contact resident care activities such as dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of central line, urinary catheter, feeding tube or tracheostomy, and wound care of any skin opening requiring a dressing. Review of the LVN job description showed one of the essential duties and responsibilities showed to follow the infection control policies. Review of the CNA job description showed one of the essential duties and responsibilities showed to follow the infection control policies. On 1/7/25 at 0834 hours and on 1/8/24 at 0948 hours, Resident 82 was observed seating in the wheelchair, in the room. There was no EBP sign posted by the resident's door. Medical record review for Resident 82 was initiated on 1/7/25. Resident 82 was admitted to the facility on [DATE]. Review of Resident 82's Order Summary Report dated 1/8/25, showed the following physician's orders dated on: - 12/12/24, for enhanced barrier precautions due to wound care on the right posterior/ lateral lower leg; and - 12/13/24, for enhanced barrier precautions due to wound care on the right posterior/ lateral lower leg. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 1/8/25 at 0948 hours, an interview was conducted with CNA 8. When asked about EBP, CNA 8 stated there should be a sign posted by the resident's door, and a star next to resident's name so the staff would know who was on isolation. CNA 8 stated if there was an EBP sign for a resident, everyone should wear a gown, mask, and gloves every time you enter the room and to wash hands before and after care. When asked if he was provided an in-service training on EBP, CNA 8 answered he was provided training by the previous DON (seven years ago). When asked for the most recent in-service training on EBP, CNA 8 answered he was provided training by the IP or the DSD. b. On 1/8/25 at 1004 hours, an interview was conducted with LVN 6. When asked about EBP, LVN 6 stated the IP should post the EBP sign by the resident's door so the staff would know the resident was on EBP. LVN 6 stated if there was an EBP sign for a resident such as when a resident had a foley catheter or a wound, the staff should wear gloves and gown only when we have to deal with the reason why the resident was on EBP. LVN 6 stated 'if we had to deal with a wound on the leg, then we have to wear PPE as a barrier. When asked if she was provided an in-service training on EBP, LVN 6 stated she was provided training by IP but did not remember the exact date. On 1/9/25 at 1619 hours, an interview was conducted with the IP. When asked if she had provided in-service training on EBP to the facility staff members, the IP stated she was still on training between November and December 2024, so she was not able to provide in-service training related to the EBP. On 1/10/25 at 1503 hours, an interview and concurrent facility document review was conducted with the DSD. When asked if she had provided in-service training on the EBP to the facility staff members, the DSD stated she assisted the previous IP in providing in-service training on the EBP, to which she provided the education program lesson plans for infection control. Review of the facility's document titled Lesson Plan on Enhanced Standard Precautions dated 4/10, 4/24, and 8/10/24, did not show CNA 8 and LVN 6 were provided with the in-service training on the EBP. The DSD verified the above findings.

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the needs for one nonsampled resident (Resident 794). * The facility failed to ensure Resident 794's order for methylphenidate (stimulant) was administered as ordered by the physician. This failure had the potential to negatively affect the residents' health and well-being. Findings: Review of the facility's P&P titled Medication Administration dated 4/2019 showed the medications are administered in a safe and timely manner and as prescribed. The medications are administered in accordance with prescriber orders, including any required time frame. Medical record review for Resident 794 was initiated on 1/7/25. Resident 794 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 794's H&P examination dated 12/28/24, showed the resident was competent and able to make decisions. Review of Resident 794's Order Summary Report dated 1/8/25, showed an order dated 12/27/24, for methylphenidate oral tablet 10 mg, give 0.5 tablet by mouth two times a day for depression manifested by feeling sad. Review of Resident 794's MAR for January 2025 showed the methylphenidate medication was administered to the resident on 1/4/25 at 1700 hours. On 1/8/25 at 1040 hours, a concurrent observation of Medication Cart A, interview, and medical record review was conducted with LVN 6. Resident 794's Controlled Drug Record failed to show the methylphenidate medication was signed as given on 1/4/25 at 1700 hours. The emergency kit was observed not to have the methylphenidate medication available. LVN 6 verified the methylphenidate was not signed on the Controlled Drug Record on 1/4/25 at 1700 hours. LVN 6 verified the emergency kit did not contain the methylphenidate. On 1/10/25 at 1006 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 - Potential for minimal harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44175 Based on interview, medical record review, and facility document review, the facility failed to ensure the Pharmacy Consultant followed up on the monthly MRR for one of five sampled residents reviewed for unnecessary medications (final sampled resident, Resident 19). This failure had the potential to cause unsafe medication doses and adverse medication reactions that can jeopardize medically compromised residents. Findings: Review of the facility's document titled Executive Summary of Consultant Pharmacist's Medication Regimen Review dated 12/11/24, showed Resident 19's medication regimen was reviewed by Pharmacy Consultant during the period of 12/1/24 to 12/11/24. Further review of the Resident 19's medical records failed to show if the monthly MRR for Resident 19 for December 2024 had recommendations or if the MRR for Resident 19 was completed with no recommendations. On 1/10/25 at 1543 hours, a concurrent interview and facility document review was conducted with RN 2. RN 2 verified the monthly MRR was conducted for Resident 19 during the period of 12/1/24 to 12/11/24. RN 2 was not able to provide whether the facility had followed up on whether Resident 19's MRR for December 2024 had any recommendations from the Pharmacy Consultant. On 1/10/25 at 1644 hours, a concurrent interview and facility document review was conducted with the DON. The DON stated he was not able to provide documented evidence if the MRR for Resident 19 for December 2024 was completed with recommendations or if the MRR completed was with no recommendations. The DON acknowledged the findings. Cross reference to F758, example #4.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Residents 84) reviewed for unnecessary medications was properly monitored related to the use opioid medication. * The facility failed to ensure Resident 84 was monitored for the side effects of receiving Norco (narcotic) medication. This failure had the potential for Resident 84 to receive unnecessary medications and develop significant side effects. Findings: Review of the facility's P&P titled Pain - clinical protocol dated 10/2022 showed the staff and physician will monitor for adverse effects of pain medications such as gastrointestinal bleeding from NSAIDs, and anorexia, confusion, lethargy, and severe constipation related to opioids. Medical record review for Resident 84 was initiated on 1/7/25. Resident 84 was admitted to the facility on [DATE] and was readmitted on [DATE]. Review of Resident 84's H&P examination dated 12/2/24, showed the resident had capacity to make medical decisions. Review of Resident 84's Order Summary Report showed an order dated 11/26/24, for Norco oral tablet 5-325 mg, one tablet by mouth every four hours as needed for moderate to severe pain, not to exceed three grams in 24 hours. Review of Resident 84's medical record did not show for the monitoring of the side effects related to the use of Norco medication, as per the facility's P&P. On 1/9/25 at 1328 hours, a concurrent interview and medical record review for Resident 84 was conducted with RN 1. RN 1 verified there was no documentation to show for the side effect monitoring of Resident 84's Norco medication. On 1/10/25 at 1006 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50953 Based on interview, medical record review, and facility P& P review, the facility failed to ensure five of five final sampled residents (Residents 5, 19, 64, 84, and 745) reviewed for unnecessary medications were free from the unnecessary psychotropic medications. * There was no evidence of non-pharmacological interventions for Resident 745's use of quetiapine (antipsychotic medication), Ativan (antianxiety medication), duloxetine (antidepressant medication) and divalproex sodium (mood stabilizer medication). Additionally, the facility failed to monitor behavior and side effects for the use of Ativan and failed to reassess the resident for use of quetiapine as needed more than 14 days. * The facility failed to show the Xanax (antianxiety medication) medication was only limited to 14 days for Resident 84. Additionally, the informed consent for the use of the Xanax medication was not completed prior to administration, and there was no evidence of non-pharmacological interventions for use of Remeron (antidepressant medication). * The facility failed to ensure the PRN order for the psychotropic medication was limited to 14 days for Residents 5 and 19. * Resident 64's informed consent for antidepressant medication, mood stabilizer and psychotropic medication was signed by the resident who was deemed not to have capacity to make decisions. These failures had the potential to result in unnecessary use of, ineffective and/ or lack of monitoring or interventions for the use of the psychotropic medications that could negatively affect Residents 5, 19, 64, 84, and 745's highest practicable mental, physical, and psychosocial well- being. Findings: Review of the facility's P&P titled Psychotropic Drug Use revised 3/2024 showed: - Nonpharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medication when possible. - Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident obtain informed written consent sign by the resident or the resident's representative along with, the signature of the health care professional declaring the required material information has been provided. - PRN orders for psychotropic medication are limited to 14 days. - the signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify the resident's health record contains written informed consent with the required signatures. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- the facility will have the resident sign the consent or if there is a responsible party, the responsible party will either sign the consent or give a verbal consent with the licensed nurses that verbal consent was received or declined. - the informed consents are maintained in the EMR (electronic medical record). Review of the facility's P&P titled Psychotropic Medication Use dated July 2022 showed the psychotropic medication are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. Further review of the P&P showed the PRN order for psychotropic medication are limited to 14 days. The P&P also showed for psychotropic medication that are not antipsychotic and if prescriber or attending physician believes it is appropriate to extend the PRN medication beyond 14 days, he or she will document the rational for extending the use and include the duration for the PRN order. 1. Medical record review for Resident 745 was initiated on 1/7/25. Resident 745 was admitted to the facility on [DATE]. Review of Resident 745's H&P examination dated 12/20/24, showed the resident was not competent. Review of Resident 745's Order Summary Report dated 1/7/25, showed the following physician orders: - dated 12/19/24, for duloxetine oral capsule 60 mg one capsule by mouth two times a day for depression manifested by verbalization of traumatic experience when he was a firefighter. - dated 12/19/24, for divalproex sodium oral capsule 125 mg two capsule by mouth three times a day for mood stabilizer manifested by mood swings - dated 12/19/24, for quetiapine fumarate oral tablet 25 mg one tablet by mouth two times a day for manic disorder manifested by auditory hallucination - dated 12/19/24, for quetiapine fumarate oral tablet 100 mg one tablet by mouth at bedtime for manic disorder manifested by auditory hallucination - dated 12/19/24, for quetiapine fumarate oral tablet 25 mg two tablet by mouth every 12 hours as needed for manic disorder manifested by auditory hallucination - dated 1/7/25, for Ativan oral tablet 0.5 mg one tablet by mouth every six hours as needed for anxiety manifested by yelling/agitation. Review of Resident 745's medical record did not show for nonpharmacological intervention monitoring for the use of the Ativan, divalproex sodium, duloxetine, and quetiapine fumarate medications. Review of Resident 745's medical record failed to show the resident was monitored for the side effects and behavior monitoring for the Ativan use. Review of Resident 745's medical record failed to show the resident was reassessed for quetiapine, as it was an as needed medication and had been more than 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 at 1339 hours, a concurrent interview and medical record review for Resident 745 was conducted with RN 1. RN 1 verified and acknowledged all the above findings. 2. Medical record review for Resident 84 was initiated on 1/7/25. Resident 84 was admitted to the facility on [DATE] and was readmitted on [DATE]. Review of Resident 84's H&P examination dated 12/2/24, showed the resident had capacity to make medical decisions. Review of Resident 84's Order Summary Report showed the following physician's orders: -dated 12/12/24, for Xanax oral tablet 0.25 mg, one tablet by mouth every eight hours as needed for anxiety manifested by verbalization of anxiousness. -dated 12/9/24, for Remeron oral tablet 15 mg, one tablet by mouth at bedtime for depression manifested by poor PO intake less than 50% . Review of Resident 84's medical record failed to show the resident was reassessed for the use of the Xanax medication, as it was an as needed medication and had been more than 14 days. Review of Resident 84's medical record failed to show an informed consent was obtained for the Xanax medication. Review of Resident 84's medical record failed to show nonpharmacological intervention monitoring for the use of the Remeron medication. On 1/9/25 at 1328 hours, a concurrent interview and medical record review for Resident 84 was conducted with RN 1. RN 1 verified there was no informed consent for the Xanax medication and Resident 84 was not reassessed for the need to continue the as needed order for the Xanax medication, the order was more than 14 days. RN 1 verified no nonpharmacological interventions were monitored for use of the Remeron medication. On 1/10/25 at 1006 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 44175 3. Medical record review for Resident 5 was initiated on 1/7/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Order Summary Report showed an order dated 11/21/24, for lorazepam (antianxiety medication) 0.5 mg give one tablet by mouth every six hours as needed for anxiety. Further review of Resident 5's medical record did not show a documented reason for the extension of the lorazepam medication beyond 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/25 at 0932 hours, a conurrent interview and medical record review for Resident 5 was conducted with LVN 4. LVN 4 verified the above findings and stated she was not able to find the documented reason for extension of the lorazepam medication beyond 14 days for Resident 5. 4. Medical record review for Resident 19 was initiated on 1/7/25. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed an order dated 12/15/24, for lorazepam 1 mg to give one tablet by mouth every 12 hours as needed for anxiety manifested by restlessness for 30 days. Further review of Resident 19's medical record did not show a documented reason for the extension of the lorazepam medication beyond 14 days. On 1/9/25 at 1359 hours, a concurrent interview and medical record review for Resident 19 was conducted with LVN 1. LVN 1 verified the above findings and stated she was not able to find the documented reason for extension of the lorazepam medication beyond 14 days for Resident 19. On 1/10/25 at 1030 hours, a concurrent interview and medical record review for Residents 5 and 19 was conducted with the DON. The DON verified the above findings and stated the PRN order for the psychotropic medications should only be limited to 14 days. The DON further stated if the resident required medication more than 14 days, then there should have been a documented reason for extension of the PRN psychotropic medication. Cross reference to F756. 50787 5. Medical record review for Resident 64 was initiated on 1/9/25. Resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 64's H&P examination dated 11/20/24, showed Resident 64 was not competent and not able to enter into a contract. Review of Resident 64's Order Summary Report dated 1/8/25, showed the following: - to administer mirtazapine (antidepressant medication) 15 mg tablet to give one tablet via GT at bedtime. - to administer quetiapine fumarate tablet, give 250 mg via GT at bedtime for bipolar disorder manifested by physically aggressive to staff. - to administer depakote oral solution 250 mg/5 ml to give 250 mg via GT one time a day for bipolar disorder manifested by sudden verbal angry outburst for no apparent reason. - to administer depakote oral solution 250 mg/5 ml to give 1000 mg via GT one time a day for bipolar disorder manifested by sudden verbal angry outburst for no apparent reason. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 64's Psychiatric Progress Note dated 12/6/24, showed with Seroquel and Depakote medications use. Review of Resident 64's Informed Consent - Psychoactive Medications showed effective date of 11/20/24, with the following listed medications: mirtazapine, quetiapine fumarate and valproic acid, including interventions and assessment of psychoactive medications, possible side effects of the medications, black box warnings, informed consent, and informed consent verification. The document showed the date and time the licensed nurse verified the verbal or telephone consent was received as 11/20/24 at 0700 hours and the name of the person who gave the verbal or telephone consent was Resident 64. On 1/09/24 at 1500 hours, a concurrent interview and medical record review of Resident 64's four paged informed consent to psychoactive medication was conducted with LVN 4. LVN 4 stated she obtained the consent for mirtazapine, quetiapine and valproic acid use from Resident 64's family with no specifics. Resident 64 had two listed contacts, Resident 64's wife and daughter however, the name of the person who gave the consent showed the name of Resident 64. On 1/10/25 at 1003 hours, a concurrent interview and medical record review of Resident 64's informed consent was conducted with the DON. The DON verified and acknowledged Resident 64's name as the person who gave the consent and stated this should have been the family member's name the staff member that was notified. On 1/10/25 1520 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. * The facility's medication error rate was 23.33%. Three of three licensed nurses (LVNs 1, 2, and 3) were found to have made errors during the medication administration observation for one sampled resident (Resident 745) and two non-sampled residents (Residents 29 and 32). This failure had the potential to negatively impact the resident's heal outcomes. Findings: Review of the facility's P&P titled Medication Administration dated 4/2019 showed the medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Review of the facility's P&P titled Administering Medication through a Metered Dose Inhaler revised 10/2010 showed the purpose of this procedure is to provide guidelines for the safe administration of inhaled medication. Assess the resident, if indicated : a. Lung sounds; b. Respiratory rate and depth; c. Cough (amount, color, and character of expectorate); d. Presence of dyspnea. 1. On 1/7/27 at 0801 hours, a medication administration observation for Resident 32 was conducted with LVN 1. LVN 1 prepared the following medications for Resident 32: - acidophilus probiotic (supplement) one billion probiotic cultures one capsule - amiodarone (antiarrythmic) 200 mg one tablet - amlodipine (calcium channel blocker) 5 mg one tablet - artificial tears lubricant (eye drop, use for dry eye) - budesonide (steroid) 0.5 mg/2 ml suspension one unit dose via handheld nebulizer - eliquis (blood thinner) 5 mg one tablet - Lasix (diuretic) 40 mg one tablet hold for systolic blood pressure below 110 - namenda (medication to treat moderate to severe dementia) 10 mg one tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- metoprolol tartrate (beta blocker) 25 mg one tablet - modafinil (stimulant) 100 mg one tablet - multi vitamins with minerals (supplement) one tablet - potassium chloride (supplement) 20 meq give one packet LVN 1 crushed the lasix during the medication administration, however there was still some medication residual observed in the medicine cup. LVN 1 also did not assess the resident's apical pulse and did not check for lung sounds prior to the medication administration. Medical record review for Resident 32 was initiated on 1/7/25. Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 32's Order Summary Report dated 1/7/25, showed the following physician's orders: - dated 10/24/23 for Lasix oral tablet 40 mg give one tablet via GT two times a day for hypertension to hold the medication for systolic blood pressure below 110. - dated 2/26/24 for budesonide inhalation suspension 0.5 mg/2 ml, 2 ml inhale orally two times a day for COPD, monitor blood pressure, apical pulse, lung sound (C-clear, W-wheezing, R-rhonchi) pre and post administration. On 1/7/25 at 1131 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 verified they did not check Resident 32's apical pulse and lung sounds prior to administration of budesonide inhalation, and verified there was lasix residual left in the medicine cup. 2. On 1/7/25 at 0913 hours, a medication administration observation for Resident 29 was conducted with LVN 2. LVN 2 prepared the following medications for Resident 29: - Augmentin (antibiotic) 500-125 mg one tablet. The bubble pack had instructions to take this medication with food to lessen chance of stomach upset. - aspirin (anti-inflammatory) chewable 81 mg one tablet - Plavix (antiplatelet) 75 mg one tablet - docusate sodium (stool softener) 100 mg two tablet - ferrous sulfate (iron supplement) 325 mg one tablet - folic acid (supplement) 1 mg one tablet - lisinopril (ACE inhibitor) 40 mg one tablet - multivitamins with minerals (supplement) one tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- nifedipine extended release (calcium channel blocker) 60 mg one tablet - Systane (eye drop, use for dry eyes) 0.6% eyedrop instill one drop to both eye LVN 2 did not give the Augmentin and ferrous sulfate medications with food to Resident 29. Medical record review for Resident 32 was initiated on 1/7/25. Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 32's Order Summary Report dated 1/7/25, showed the following physician's orders: - dated 1/6/25 for Augmentin oral tablet 500-125 mg one tablet by mouth three times a day for cellulitis left antecubital for 10 days. - dated 1/2/25, for ferrous sulfate oral tablet 325 mg give one tablet by mouth two times a day to take with food On 1/7/25 at 1138 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 verified they did not give the Augmentin and ferrous sulfate with food and stated the order for giving Augmentin with food needed to be clarified with the physician since the bubble pack label instruction was to take the antibiotic medication with food. 3. On 1/7/27 at 0954 hours, a medication administration observation for Resident 745 was conducted with LVN 3. LVN 3 prepared the following medications for Resident 745: - gabapentin (anticonvulsant) 300 mg one capsule - depakote (anticonvulsant) two capsules - acetaminophen (pain reliever) 325 mg two tablet - multi vitamins with minerals (supplement) one tablet - Vitamin D (supplement) 1000 IU two tablet LVN 3 did not administer tamsulosin, duloxetine, and quietapine to Resident 745. Medical record review for Resident 745 was initiated on 1/7/25. Resident 745 was admitted to the facility on [DATE]. Review of Resident 745's H&P examination dated 12/20/24, showed the resident was not competent and not able to enter into a contract, including admission agreement. Review of Resident 745's Order Summary Report dated 1/7/25 showed the following physician's orders: -dated 12/19/24 for tamsulosin (to treat symptom of enlarged prostate) oral capsule 0.4 mg, two capsule by mouth one time a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-dated 12/19/24, for duloxetine (antidepressant) oral capsule 60 mg one capsule by mouth two times a day for depression manifested by verbalization of traumatic experience when he was a firefighter. -dated 12/19/24, for quetiapine fumarate (antipsychotic) oral tablet 25 mg one tablet by mouth two times a day for manic disorder manifested by auditory hallucination. On 1/7/25 at 1136 hours, a concurrent interview and medical record review for Resident 745 was conducted with LVN 3. LVN 3 verified did not administer tamsulosin, duloxetine, and quetiapine fumarate medications. LVN 3 further verified all the medications were signed as given on MAR. On 1/7/25 at 1334 hours, an interview was conducted with DON and Administrator. The DON and Administrator verified and acknowledged findings.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (final sampled resident, Resident 745) was free from the significant medication errors. This failure placed Resident 745 at risk for medical complications. Findings: Review of the facility's P&P titled Medication Administration dated 4/2019 showed the medications are administered in a safe and timely manner, and as prescribed. The medications are administered in accordance with prescriber orders, including any required time frame. Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy date 4/2008 showed to reorder medication five days in advance of the need to assure for an adequate supply is on hand. Medical record review for Resident 745 was initiated on 1/7/25. Resident 745 was admitted to the facility on [DATE]. Review of Resident 745's Order Summary Report dated 1/7/25, showed the following physician orders: - dated 12/19/24, for duloxetine (antidepressant medication) oral capsule 60 mg one capsule by mouth two times a day for depression manifested by verbalization of traumatic experience when he was a firefighter. - dated 12/19/24, for quetiapine fumarate (antipsychotic medication) oral tablet 25 mg one tablet by mouth two times a day for manic disorder manifested by auditory hallucination - dated 12/19/24, for tamsulosin (to treat symptom of enlarged prostate) oral capsule 0.4 mg, two capsule by mouth one time a day. On 1/7/27 at 0954 hours, a medication administration observation for Resident 745 was conducted with LVN 3. LVN 3 did not administer the tamsulosin, duloxetine, and quietapine fumarate medications to Resident 745. On 1/7/25 at 1136 hours, a concurrent interview and medical record review for Resident 745 was conducted with LVN 3. LVN 3 verified they did not administer the tamsulosin, duloxetine, and quetiapine fumarate medications. LVN 3 further verified all the medications were signed as given on the MAR. On 1/7/25 at 1212 hours, a concurrent interview and medical record reviewed was conducted with the Pharmacy Consultant. The Pharmacy Consultant stated the tamsulosin, duloxetine and quetiapine fumarate medications were filled on 12/19/24 for 14 days supply. There was a refill request on 12/26/24, not able to refill. According to the pharmacy's calculation on 1/2/25, the last dose of medication to administered was on 1/2 and 1/3/25, and there were no more medications available. Review of the MAR for 12/2024 and 1/2025 showed no documentation Resident 745 had refused any of the above medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 1334 hours, an interview was conducted with DON and Administrator. The DON and Administrator verified and acknowledged above findings. Cross reference to F759.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper medication storage. * The facility failed to ensure the expired medications were removed from the medication cart * The facility failed to ensure the medications were stored and labeled properly * The facility failed to ensure a bag containing several wound dressings, a tube of CalProtect topical ointment (medication used to treat minor skin irritations) and two tubes of Triad hydrophilic wound dressing ointment (a zinc-oxide based sterile coating used to manage low to moderate levels of wound exudate) were not left at the resident's bedside. * The facility failed to ensure Residents 58 and 494's medications were not left unattended in the residents' rooms. * The facility failed to maintain the accurate labeling to facilitate consideration of precautions and safe administration, of medications; and safe and secure storage of all medications to Resdient 81. * The facility failed to ensure a packet of Vitamin A&D (skin moisturizer) was not left at Resident 56's bedside table These failures had the potential to negatively impact the residents' well-being, and medication errors. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the expiration/beyond the use date on the medication is checked prior to administering. 1a. On 1/8/25 at 0803 hours, an inspection for Medication Cart C was conducted with LVN 5. During the inspection of Medication Cart C, the following was observed: - seven individual packs of skin integrity Hydrogel impregnated gauze (a medical dressing where a soft, water-based gel (hydrogel) is absorbed into a gauze material), sealed, with expiration date of 12/2024 - five individual packs of skin integrity Hydrogel impregnated gauze, sealed, with expiration date of 9/2023 - seven individual packs of Curad oil emulsion dressing (a nonadherent gauze mesh impregnated with white petrolatum in an oil emulsion blend), sealed, with expiration date of 1/2/24 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11 individual packs of Curad oil emulsion dressing sealed with expiration date of 9/8/24 - two individual packs of open Medi-strip reinforced wound closure - one individual pack of bordered gauzed with adhesive border cut and open - one individual pack of Aquacel (a hydrofiber wound dressing used to treat wounds that are moderately to heavily exuding)10 x 12 cm open and cut - two individual packs of open and cut Medi strip reinforced wound closure, with package's description showed it was a single use only dressing - one individual pack of Collagen wound dressing open, with package's description showed it was a single use only dressing - one individual pack of calcium alginate dressing (a non-toxic, absorbent wound dressing made from seaweed) 10 x 10, sealed, with expiration date of 8/28/23 - one individual pack of calcium alginate dressing 10 x 10, sealed, with expiration date of 10/21/24 - one individual pack of open Opti foam gentle silicone faced foam and border (used for for partial and full-thickness wounds that are moderately to severely draining) On 1/8/25 at 0833 hours, an interview was conducted with LVN 5. LVN 5 was asked the process of opening an individual pack supply. LVN 5 stated individual pack is single use only and needs to be discarded after single use. The LVN 5 verified all the above findings. b. On 1/8/25 at 1023 hours, an inspection for Medication Cart A was conducted with LVN 6. During the inspection of Medication Cart A, one bottle of Active liquid Protein Concentrated nutrition sealed was noted with an expiration date of 12/1/24. On 1/8/25 at 1040 hours, an interview was conducted with LVN 6. LVN 6 verified and confirmed above findings. c. On 1/8/25 at 1052 hours, an inspection of Medication Cart C and interview was conducted with LVN 4. One bottle of Active liquid Protein Concentrated nutrition was observed open with an expiration date of 12/1/24. LVN 4 verified the findings. d. On 1/7/25 at 1232 hours, an inspection of Medication Room A and interview was conducted with RN 1. One Covid self-test was observed with an expiration date of 12/20/23. RN 1 showed extended expiration date for the Covid test for one year 12/20/24. RN 1 verified the findings. e. On 1/7/25 at 1251 hours, an inspection of Medication Room B was conducted with RN 1. There was one Amjevita auto injection (used to treat inflammatory diseases) 40 mg/0.4 ml medicine without a label of the resident's name and open date. RN 1 verified the above findings. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/25 at 1006 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39453 2. On 1/7/25 at 0834 hours, during the initial tour of the facility, a bag containing several wound dressings, a tube of CalProtect topical ointment and two tubes of Triad hydrophilic wound ointment was observed on Resident 82's nightstand. Resident 82 stated she did not know anything about the wound dressing and wound care ointments, and the nurse applied those to her right leg wound. Medical record review for Resident 82 was initiated on 1/7/25. Resident 82 was admitted to the facility on [DATE]. Review of Resident 82's Order Summary Report dated 1/8/25, showed the following physician's orders: - dated 12/13/24, for the left lower leg with dry and scaly skin, cleanse with normal saline, apply with moisturizing cream and leave open to air; - dated 12/13/24, for the right lower leg with dry and scaly skin, cleanse with normal saline, apply with moisturizing cream and leave open to air; - dated 12/26/24, for the right posterior/ lateral lower leg peripheral arterial disease wound, cleanse with normal saline, apply collagen then cover with rolled gauze. - dated 12/26/24, for the left foot second two peripheral arterial disease wound, to paint with betadine (an antiseptic) and leave open to air; - dated 12/26/24, for the left foot third two peripheral arterial disease wound, to paint with betadine and leave open to air; and - dated 12/26/24, for left foot fourth two peripheral arterial disease wound, to paint with betadine and leave open to air. On 1/7/25 at 1013 hours, a concurrent observation for Resident 82 and interview was conducted with LVN 5. A bag containing several wound dressings, a tube of CalProtect topical ointment and two tubes of Triad hydrophilic wound ointment was observed on Resident 82's nightstand. LVN 5 verified the above findings. LVN 5 stated the bag containing the wound dressings and ointments may have been from when Resident 82 was admitted . 44175 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's P&P titled Storage of Medications revised 2/2023 showed the drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls and only persons have access to locked medications. The medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Compartments containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Further review of the P&P showed the nursing staff was responsible for maintaining medication storage and preparation areas clean, safe, and sanitary manner. a. On 1/7/25 at 0929 hours, a concurrent observation and interview was conducted with Resident 58. Two medication cups containing white pasty cream with wooded spatula were observed on top of the nightstand on the left side of the Resident 58's bed. Resident 58 was observed lying in bed with the night stand next to her. There was no licensed staff inside the room. Resident 58 stated the medication cream was for her back and the staff applied the medication on her back. Medical record review for Resident 58 was initiated on 1/7/25. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's H&P examination dated 9/20/24, showed Resident 58 was competent and able to make decisions. b. On 1/7/25 at 0931 hours, a concurrent observation and interview was conducted with Resident 494. A medication cups containing white pasty cream with wooded spatula was observed on top of the nightstand on the right side of the Resident 494's bed. Resident 494 was observed lying in bed with the night stand next to her. There was no licensed staff inside the room. Resident 494 stated she did not know about the medication that was left at her nightstand. Medical record review for Resident 494 was initiated on 1/7/25. Resident 494 was admitted to the facility on [DATE]. Review of Resident 494's H&P examination dated 12/20/24, showed Resident 494 had the capacity to understand and make medical decisions. On 1/7/25 at 0942 hours, a concurrent observation and interview was conducted with RN 1. RN 1 verified the above observations and stated the white pasty substance in the medication cup on the nighstand of Resident 58 and 494 looked like zinc oxide. RN 1 further stated the nursing staff should not have left the medication at the bed side of Resident 58 and 494 unattended. On 1/9/25 at 1445 hours, the DON was informed and acknowledged the above findings. 50787 c. On 1/7/25 1147 hours, a concurrent observation of Resident 81's room and interview was conducted with CNA 1. A white cream was observed inside a small cup with a tongue depressor on top of Resident 81's bedside stand. CNA 1 was asked what the white cream was. CNA 1 stated it was for Resident 81, and the treatment nurse used it on the resident. (continued on next page)

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Harbor Villa Care Center	861 S. Harbor Blvd Anaheim, CA 92805

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review of Resident 81 was initiated on 1/9/24. Resident 81 was initially admitted on [DATE] and readmitted on [DATE]. On 1/8/25 at 1008 hours, a concurrent interview and medical record review was conducted with LVN 5. LVN 5 identified the cream as zinc oxide cream and verified it was used. Review of Resident 81's physician's orders and treatment administration record did not show an order for the zinc oxide cream. LVN 5 verified there was no order to use the cream for the resident and need one. On 1/10/24 at 1520 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged and verified the above findings. 49644 4. On 1/8/25 at 0902 hours, a concurrent observaation and interview was conducted with Resident 56. Resident 56 was observed lying in bed and using her cellphone. One Vitamin A&D packet was observed on Resident 56's bedside table. Resident 56 stated the nurses applied the Vitamin A&D ointment to her skin. Medical record review for Resident 56 was initiated on 1/7/25. Resident 56 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 56's Order Summary Report for January 2025 showed the following physician's orders: - dated 12/11/2024, LLE Dryness: Apply Vitamin A&D and leave open to air every day for 30 days; and - dated 12/11/2024, RLE Dryness: Apply Vitamin A&D and leave open to air every day for 30 days. On 1/7/25 at 1019 hours, a concurrent observaation and interview was conducted with LVN 1. LVN 1 verified the Vitamin A&D ointment packet was on Resident 56's bedside table. LVN 1 stated the Vitamin A&D packet should not be left on Resident 56's bedside table. On 1/10/25 at 1631 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175 Based on observation, interview, and facility document review, the facility failed to ensure the food served to the residents was palatable. * The cooked broccoli was mushy in texture. This failure had the potential for the residents to not eat the food served and could affect their nutritional status. Findings: Review of the facility's document titled Diet Type Report dated 1/7/25, showed 89 of 92 residents were receiving food prepared from the kitchen. Review of the facility's Menu showed on 1/8/24, the noon meal selection included Seas Broccoli Florets (edible flower-shaped pieces of a brocolli). Review of the facility's document titled Seas Broccoli Florets (undated) showed to place the broccoli in a steamer or stockpot with water and to cook until tender but not mushy. On 1/7/25 at 1022 hours, an interview was conducted with Resident 5. Resident 5 stated the food in the facility did not taste good. Medical record review for the Resident 5 was initiated on 1/7/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 11/20/24, showed Resident 5 was competent and able to make decisions. On 1/8/25 at 1318 hours, a test tray inspection was conducted with the CDM, RNA 1, and LVN 4. The regular diet tray included the broccoli. The broccoli was observed mushy and overcooked. RNA 1 verified the observation and stated broccoli was cooked a little more. LVN 4 stated the broccoli was softer than it should have been. On 1/9/25 at 1445 hours, the DON was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44175 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when: * The facility failed to ensure two coffee pots were not stored wet. * The facility failed to ensure the kitchen equipment and utensils were maintained in a sanitary condition. * The facility failed to ensure the food preparation sink had a back flow prevention in place. These failures had the potential to result in foodborne illnesses for residents receiving kitchen services in the facility. Findings: Review of the facility's document titled Diet Type Report dated 1/7/25, showed 89 of 92 residents were receiving food prepared from the kitchen. 1. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. On 1/7/25 at 0800 hours, an observation and concurrent interview was conducted with the CDM. Two coffee pots were observed stored wet in the coffee station inside the kitchen. The CDM verified the observation and stated the staff should have air dried the coffee pots before storing. 2. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils. Equipment food - contact surfaces and utensils shall be clean to sight and touch. a. On 1/7/25 at 0800 hours, an observation and concurrent interview was conducted with the CDM. The following were observed: - A white freezer was observed with a brownish black discoloration on the Styrofoam lining inside the freezer. Food was observed stored in the freezer. - Four small red bowls with dried food crumbs were observed stored in a clean dish storage area. The CDM verified the above observations and stated the white freezer needed to be cleaned and the four small red bowls should have been thoroughly cleaned before the bowls were stored in a clean dish storage area. The CDM was observed taking the four small red bowls with dry food crumbs to the dishwashing area for cleaning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of the facility's P&P titled Ice Machine and Ice Storage Chests dated November 2022 showed the ice machines and ice storage distribution containers will be used and maintained to assure a safe and sanitary supply of ice. On 1/8/25 at 0953 hours, an observation of the ice machine and concurrent interview was conducted with the Maintenance Director. When the Maintenance Director was asked to open the metal cover of the ice machine, the inside lining of the door of the ice machine was observed peeling off with sticky brown discoloration. The Maintenance Director verified the observation and acknowledged the peeling of the inside lining of the ice machine was not a cleanable surface and needed to be fixed. 3. According to the USDA Food Code 2022 Section 5-402.11 Backflow Prevention, (A) .a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 1/8/25 at 0953 hours, an observation and concurrent interview was conducted with the Maintenance Director. An observation of the plumbing of the food preparation sink located adjacent to the CDM's office was conducted. The drain pipe of the food preparation sink did not have a backflow prevention in place. The Maintenance Director verified the observation and stated he was not able to show if the food preparation sink had the system to prevent the back flow from the sewage system.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for one of 19 final sampled residents (Resident 24) and one of three closed record residents (Resident 92) were complete and accurately documented. * The facility failed to ensure Resident 24's POLST was signed by the legal decisionmaker. * The facility failed to ensure Resident 92's Vital Signs Summary was accurate. These failures had the potential for the residents' needs not being met as the medical information were incomplete and inaccurate. Findings: Review of the facility's P&P titled Charting and Documentation revised ,d+[DATE] showed all the 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. The Policy Interpretation and Implementation section showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Medical record review for Resident 24 was initiated on [DATE]. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's POLST dated ,d+[DATE], failed to show the signature of Resident 24's legal decisionmaker. On [DATE] at 1012 hours, an interview and concurrent medical record review for Resident 24 was conducted with LVN 1. LVN 1 verified Resident 24's POLST had no signature on the space for the Signature of Patient or Legally Recognized Decisionmaker. LVN 1 stated Resident 24's POLST should have been signed so the staff would know if it was valid. LVN 1 stated the licensed nurse or social worker should contact the family to make sure Resident 24's POLST was valid. On [DATE] at 1631 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Closed medical record review for Resident 92 was initiated on [DATE]. Resident 92 was admitted to the facility on [DATE]. Review of Resident 92's Record of Death (undated), showed Resident 92's date of death was [DATE] at 2030 hours. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 92's Weights and Vital Signs Summary showed the following vital signs documented on [DATE] at 0018 hours: - Blood Pressure - ,d+[DATE] mmHg; - Oxygen Saturation - 98% (room air); - Pulse - 74 bpm (regular); - Respiration - 18 (breaths/min); and - Temperature - 97.8 (forehead, non-contact). On [DATE] at 1102 hours, an interview and concurrent medical record review for Resident 92 was conducted with LVN 1. LVN 1 stated Resident 92 expired on [DATE]. LVN 1 verified the vital signs were documented on Resident 92's electronic health record on [DATE]. LVN 1 stated the licensed nurse documented the vital signs on the electronic health record. On [DATE] at 1057 hours, an interview and concurrent medical record review for Resident 92 was conducted with the DON. The DON acknowledged Resident 92 expired on [DATE]. The DON verified the vital signs were documented on [DATE], one day after the resident expired. The DON stated it happened due to the licensed staff's carelessness. The DON stated the staff should have deactivated Resident 92's account and changed the status to discharged so nobody could mistakenly enter unnecessary documentation.

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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** 44175 Based on interview, medical record review, and facility document review, the facility failed to ensure one of one resident (final sampled, Resident 52) reviewed for hospice services had received the necessary care and services. * The facility failed to ensure the hospice visit calendar was available in Resident 52's residents' medical record. * The facility failed to ensure for an accurate documentation of the hospice staff visits were available for Resident 52. * The facilty failed to ensure the hospice staff visited the resident as scheduled in the hospice calendar for Resident 52. These failures posed the risk for the delay in communication and provision of hospice care between the hospice provider and facility . Findings: Review of the facility's document titled Hospice Services Agreement with Hospice Provider A dated 2/23/23, showed: - The hospice provider will ensure that patient's visit will be made at a time mutually agreed upon by provider and patient. - The hospice provider will ensure complete physical assessment will be completed by an RN employee of Hospice Provider A, and ongoing assessment will be done each time that the patient is visited by a skilled nurse. Medical record review for Resident 52 was initiated on 1/7/25. Resident 52 was admitted to the facility on [DATE]. Review of Resident 52's Physician Order Summary dated 1/9/25, showed a physician's order dated 6/21/24, to admit Resident 52 in the facility under Hospice Provider A. a. Review of the Resident 52's hospice provider Plan of Care dated 12/2/24, showed the following: - Skilled nurse to visit one time weekly and eight visits as needed; - Hospice aide to visit two times a week; and - Social worker to visit one time a month and three visits as needed. (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 the Resident 52's medical records did not show a calendar for January 2025, to show the schedule when the hospice staff were visiting Resident 52. On 1/9/25 at 1028 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified the above findings and stated the skilled nurse from Hospice Provider A visited Resident 52 every Thursday, and she was not sure about the schedule of hospice aide and which days the hospice aide visited Resident 52. LVN 6 verified the hospice visit calendar for January 2025, was not in Resident 52's medical records. b. Review of hospice calendar for December 2024, for Resident 52, showed a skilled nurse to visit every Thursdays (12/ 5, 12/12, 12/19, and 12/26/2024), hospice aide to visit twice a week on Tuesdays and Fridays (12/3, 12/6, 12/10, 12/13, 12/17, 12/20, 12/24, and 12/27/2024), and a social worker to visit on 12/18/2024. Review of the facility document titled Hospice Provider A Flowsheet for December 2024 did not show the name of Resident 52, and showed the entries dated 12/5, 12/10, 12/12, 12/13, 12/20, 12/12, and 12/24/2024. Further review of the entries on the above dates did not show the designation of the person who visited. Further review of the document did not show if the hopice staffs (skilled nurse, hospice aid, and social worker) visited as scheduled in the calendar for December 2024. On 1/10/25 at 1319 hours, an interview and concurrent medical record review for Resident 52 was conducted with LVN 6. LVN 6 verified the above findings and stated the Hospice Provider A Flowsheet for December 2024 was for Resident 52. LVN 6 also stated there were no other residents in the facility with the Hospice Provider A. LVN 6 stated she was not able to verify if the hospice staff visited Resident 52 as scheduled in the calendar for December 2024 and if their plan of care was followed. On 1/10/25 at 1445 hours, an interview and concurrent medical record review for Resident 52 was conducted with the DON. The DON verified and acknowledged the above findings.

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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** 49644 Based on observation, interview, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the facility had monthly Infection Prevention and Control Surveillance logs for July, September, and December 2024. * The facility failed to ensure the facility's infection surveillance log for August through November 2024 included if the resident met the Loeb's criteria for true infection. * The facility failed to ensure the October and November 2024 Infection Prevention and Control QA Reports were accurate. * The facility failed to ensure the facility had a surveillance log to show the residents who met and not met the Loeb's criteria. * The IP failed to include residents with signs and symptoms of infection but were not prescribed with antibiotic on the infection surveillance report. * The facility failed to ensure Resident 694's Infection Screening Evaluation form showed whether the resident met or not met the Loeb's Criteria. * The facility failed to ensure staff performed hand hygiene after removing gloves during medication administration for one of three resident (Resident 32). * The facility failed to ensure the staff performed hand hygiene during the wound care treatment for Resident 19. * The facility failed to ensure Resident 14's Foley catheter bag was not on the floor. * The facility failed to ensure the EBP was implemented and the EBP sign was posted outside of resident's door for Resident 82. These failures posed the risk for not identifying infections and controlling the transmission of communicable disease to other resident through the facility. Findings: Review of the facility's P&P titled Policies and Practices - Infection Control revised 10/2018 showed the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. (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 the facility's P&P titled Surveillance for Infections revised 9/2017 showed the infection preventionist will conduct ongoing surveillance for healthcare-associated (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The Policy Interpretation and Implementation section showed the purpose of infection surveillance is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions (Loeb's criteria to initiate antibiotics, Revised McGeers for infection), and will document and report suspected infections to the charge nurse as soon as possible. The Gathering Surveillance Data section showed the infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI committee may be involved in interpretation of data. Review of the facility's P&P titled Healthcare-Associated Infections, Identifying revised 9/2017 showed the healthcare-associated infections (HAIs) are those that are acquired during the delivery of healthcare across settings, in contrast to those that were acquired prior to entering the healthcare setting but may persist after admission to the facility. Review of the facility's P&P titled Infection Preventionist revised 9/2022 showed the infection preventionist is responsible for coordinating the implementation and updating of the infection prevention and control program. Review of the facility's P&P titled Antibiotic Stewardship revised 12/2016 showed the antibiotics will be prescribed and administered to the residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Review of the facility's P&P titled Enhanced Barrier Precautions revised 8/2022 showed the enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. 1. Review of the facility's infection control binder failed to show documentation of the monthly Infection Prevention and Control Surveillance log for July, September, and December 2024. On 1/8/25 at 1151 hours, an interview and concurrent record review of the facility's infection control program was conducted with the IP. The IP verified there was no Infection Prevention and Control Surveillance log for July, September, and December 2024. The IP further stated there was no Infection Prevention and Control Surveillance log for September 2024 because the previous IP left the facility. The IP stated she completed the surveillance report for October and November 2024. On 1/9/25 at 1620 hours, a follow up interview was conducted with the IP. The IP stated she just found the Infection Prevention and Control Surveillance log for July 2024 last night in the system (computer). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 1657 hours, an interview and concurrent record review was conducted with the DON. The DON verified there was no Infection Prevention and Control Surveillance log for September and December 2024. The DON stated the IP was new and he had no idea why the surveillance log for September and December 2024 were not done. 2. On 1/8/25 at 1151 hours, an interview and concurrent record review was conducted with the IP. The IP stated the facility was using the Loeb's criteria to assess for true infection. The IP verified the infection surveillance log for August through November did not include if the resident met the Loeb's criteria for true infection. However, review of the records showed the August 2024 Infection Prevention and Control Surveillance log included residents that met or not met McGeers criteria instead of the Loeb's criteria. The October and November 2024 Infection Surveillance Monthly Report did not show whether the resident met or not met the Loeb's criteria. On 1/9/25 at 1657 hours, an interview and concurrent record review was conducted with the DON. The DON verified the records for August 2024, Infection Prevention and Control Surveillance log included residents who met or not met McGeers criteria instead of the Loeb's criteria. The October and November 2024 Infection Surveillance Monthly Report did not show whether the resident met or not met the Loeb's criteria. The DON stated it was his first time to see the October and November 2024 Infection Surveillance Monthly Report. 3. On 1/8/25 at 1151 hours, an interview and concurrent record review was conducted with the IP. The Infection Prevention and Control October 2024 QA Report showed the following: - Total infection-62; - CAI-38; and - HAI-8. The Infection Surveillance Monthly Report for October 2024 showed the following: - Total infection-44; - CAI-23; and - HAI-23. The Infection Prevention and Control November 2024 QA Report showed the following: - Total infection-31; - CAI-16; and - HAI-15. The Infection Surveillance Monthly Report for November 2024 showed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Total Infection-18; - CAI-16; and - HAI 15. The IP verified the October and November 2024 Infection Prevention and Control QA Report were not accurate. The October and November 2024 Infection Prevention and Control QA Report did not match the October and November 2024 Infection Surveillance Monthly Report. In addition, the total number of infections between HAI and CAI for November and December were not the same count of total infections for both months identified. When asked to explain regarding the difference/inaccuracies between the datas , the IP stated she did not know. The IP verified she was the one who prepared the October and November 2024 Infection Prevention and Control QA Report and the October and November 2024 Infection Surveillance Monthly Report. On 1/9/25 at 1657 hours, an interview and concurrent record review was conducted with the DON. The DON verified the October and November 2024 Infection Prevention and Control QA Report did not match the October and November 2024 Infection Surveillance Monthly Report. The DON stated he has not seen the Infection Prevention and Control QA Report and the Infection Surveillance Monthly Report before. 4. On 1/8/25 at 1151 hours, an interview and concurrent record review was conducted with the IP. The IP verified she did not have a surveillance log to show the residents who met and not met the Loeb's criteria. On 1/9/25 at 1620 hours, a follow up interview was conducted with the IP. The IP acknowledged she did not have a log to track those residents who met and not met the Loeb's Criteria. 5. Review of the facility's EBP signage showed everyone must perform hand hygiene before entering the room. Anyone anticipating in any of these six moments must also don gown and gloves. Change and discard gown and gloves and perform hand hygiene between each resident and before leaving room. The EBP six moments were morning & evening care, toileting and changing incontinence briefs, device care or use, wound care, transferring and preparing to leave room, and changing linens. On 1/8/25 at 1101 hours, an interview was conducted with the IP. When the IP was asked about the six moments of the EBP, the IP was not able to answer the question. On 1/8/25 at 1151 hours, a follow up interview was conducted with the IP. The IP stated she has been asking the facility for more training. The IP further stated she had a total of four days training for the IP role. The IP stated she completed an online training but it was different from the actual floor training in the facility. 6. On 1/9/25 at 1620 hours, an interview and concurrent record review was conducted with the IP. The IP stated she only included the residents who were prescribed with the antibiotics on the infection surveillance report. The IP stated she did not include those residents with signs and symptoms of infection and were not prescribed with antibiotics. 7. Medical record review for Resident 694 was initiated on 1/9/25. Resident 694 was admitted to the facility on [DATE]. (continued on next page)

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	055742	A. Building B. Wing	01/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 694's H&P examination dated 12/10/24, showed Resident 694 had the capacity to make medical decisions. The H&P showed a diagnosis of cellulitis of unspecified part of limb. On 1/9/25 at 1620 hours, an interview and concurrent medical record review for Resident 694 was conducted with the IP. When the IP was asked about the Loeb's criteria, the IP showed Resident 694's Infection Screening Evaluation form. Review of the Resident 694's Infection Screening Evaluation form did not show whether the resident met or not met the Loeb's Criteria. The IP stated she should have typed in the comment section of the Infection Screening Evaluation form whether the resident met or not met the Loeb's criteria. 50953 8. Review of the facility P&P titled Personal Protective Equipment - Using Gloves revised 9/2010 showed the facility objectives to prevent the spread of infection. Perform hand hygiene after removing gloves. On 1/7/25 at 0801 hours, a medication administration observation for Resident 32 was conducted with LVN 1. LVN 1 was observed removing the gloves and putting on another pair of gloves without performing hand hygiene. On 1/7/25 at 1131 hours, an interview was conducted with LVN 1. LVN 1 verified the findings. On 1/10/25 at 1006 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 44175 9. Review of the facility's P&P titled Hand Washing/Hand Hygiene dated October 2023, showed the facility considered hand hygiene the primary means to prevent the spread of the health care associated infection. Hand hygiene was indicated for the following situations: - After contact with blood, body fluids, or contaminated surfaces; - Immediately after glove removal. Further review of the facility's P&P showed the use of the gloves does not replace hand washing/hand hygiene. Medical record review for Resident 19 was initiated on 1/7/25. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed the following physician's orders: - dated 12/6/24, for the left buttocks extending to left posterior thigh fungal dermatitis related to MASD, to clean with normal saline, pat dry, apply zinc oxide (medicine to treat or prevent minor skin irritations such as burns, cuts, and diaper rash) ointment and leave open to air every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 12/26/24, for the left thigh (front) fungal dermatitis related to MASD, to cleanse with normal saline, pat dry, apply zinc oxide and leave open to air every shift for 21 days. On 1/10/25 at 0758 hours, a wound care observation for Resident 19 was conducted with LVN 5. Resident 19 was observed being awake in bed. LVN 5 was observed performing a hand hygiene and donning a clean pair of gloves. LVN 5 was then observed cleaning Resident 19's wound on left buttock extending to left posterior thigh with normal saline. LVN 5 then changed to a clean pair of gloves without performing hand hygiene and proceeded to apply zinc oxide to the wound on left buttock extending to left posterior thigh and left the wound open to air. LVN 5 then doffed her gloves and performed hand hygiene. LVN 5 was then observed donning a clean pair of gloves and proceeded to clean wound on left thigh (front) with normal saline. LVN 5 was again observed changing to a clean pair of gloves without performing hand hygiene and proceeded to apply zinc oxide to the wound on the left thigh (front) and left the wound open to air. On 1/10/25 at 0815 hours, an interview was conducted with LVN 5. LVN 5 verified the above observation and stated she was nervous and forgot to perform a hand hygiene in between glove changes during the wound care for Resident 19. LVN 5 further stated she should have performed a hand hygiene before donning each pair of clean gloves. On 1/10/25, 1030 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 48332 10. Review of facility's P&P titled: Emptying a Urinary Collection Bag, Nursing Policy and Procedure Manual for Long Term Care; revised August 2022 showed to keep the collection bag and tubing off the floor at all times to prevent contamination and damage. Medical record review for Resident 14 was initiated on 1/7/25. Resident 14 was admitted to facility on 5/31/24. Review of the Order Summary Report dated 1/8/25, showed a physician's order dated 10/2/24, for F/C size FR# 16/10 cc to BSD. On 1/07/25 at 0926 hours, an observation was conducted for Resident 14. Resident 14's bed was observed on low position and the indwelling urinary catheter bag was observed laying on the floor. On 1/07/25 at 1033 hours an interview and concurrent observation for Resident 14 was conducted with the DON. The DON verified the findings and stated the indwelling urinary bag should not be directly laying on the floor. 39453 11. On 1/7/25 at 0834 hours and on 1/8/24 at 0948 hours, Resident 82 was observed seating in the wheelchair, in the room. There was no EBP signed posted by the door nor a PPE cart. Medical record review for Resident 82 was initiated on 1/7/25. Resident 82 was admitted 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 82's Order Summary Report dated 1/8/25, showed the following physician's orders: - dated 12/12/24, for enhanced barrier precautions due to wound care on the right posterior/ lateral lower leg; and - dated 12/13/24, for enhanced barrier precautions due to wound care on the right posterior/ lateral lower leg. a. On 1/8/25 at 0948 hours, an observation for Resident 82 and concurrent interview was conducted with CNA 8. Resident 82 was observed sitting in the wheelchair, in the room. There was no EBP signed posted by the door nor a PPE cart by the resident's door. CNA 8 verified the above findings. When asked about the Enhanced Barrier Precautions, CNA 8 stated there should be a sign posted by the resident's door, and a star next to resident's name so the staff would know who was on isolation. b. On 1/8/25 at 1004 hours, an observation for Resident 82 and concurrent interview and medical record review was conducted with LVN 6. Resident 82 was observed sitting in the wheelchair, in the room. There was no EBP signed posted by the door nor a PPE cart by the resident's door. LVN 6 verified the above findings. When asked about the Enhanced Barrier Precautions, LVN 6 stated the IP should post the EBP sign by the resident's door so the staff would know who was on the EBP.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 49644 Based on interview, facility document review, and facility P&P review, the facility failed to implement their Antibiotic Stewardship Program when the IP was not able to show the documentation she notified the physician of the residents who were prescribed antibiotics and did not meet the Loeb's Criteria. This failure had the potential for inaccurately identifying for true infections and potentially inhibited residents from receiving the appropriate treatment and care. Findings: According to the CDC, the antibiotics are some of the most commonly prescribed medications in nursing homes. Over the course of a year, up to 70% of nursing home residents get an antibiotic. Roughly 40% to 75% of antibiotics are prescribed incorrectly. In nursing homes, high rates of antibiotics are prescribed to prevent urinary tract infection (UTI) and respiratory tract infection (RTI). Prescribing antibiotics before there is an infection often contributes to misuse. Often residents are given antibiotics just because they are colonized with (carrying) bacteria that are not making the person sick. Prescribing antibiotics for colonization contributes to antibiotic overuse. When patients are transferred between facilities, for example from a nursing home to a hospital, poor communication between facilities about prescribed antibiotics (e.g., rationale, number of days) plus insufficient infection control practices can result in antibiotic misuse and the spread of antibiotic resistance. Antibiotic-related harms, such as diarrhea from C. difficile, can be severe, difficult to treat, and lead to hospitalization s and deaths, especially among people over age 65. Review of the facility's P&P titled Antibiotic Stewardship revised 12/2016 showed the antibiotics will be prescribed and administered to the residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. On 1/9/25 at 1620 hours, an interview and concurrent record review was conducted with the IP. The IP was asked to show for the documentation she notified the physician of the residents who were prescribed antibiotics and did not meet the Loeb's Criteria. The IP was not able to show documentation the physicians were notified of the residents who were prescribed antibiotics and did not meet the Loeb's Criteria. On 1/10/25 at 1049 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the IP should have notified the physician of the residents who were prescribed antibiotics but did not meet the Loeb's criteria.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep all essential equipment working safely. 44175 Based on observation and interview, the facility failed to ensure the frozen storage area inside the residents' refrigerator, located in Station B was free of ice buildup. This failure had the potential for the food stored in the freezer area to not maintain the proper temperature. Findings: On 1/7/25 at 0846 hours, an observation and concurrent interview was conducted with RN 1. The only refrigerator in the facility to store the residents' food located in Station B was observed with the ice buildup in the frozen storage area. The frozen storage area was observed inside residents' refrigerator with no separate door for the frozen storage area. The food for a resident was observed stored in the refrigerator. RN 1 verified the observations and stated the above refrigerator needed to be defrosted. On 1/9/25 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.