STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055755	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Care Center	8167 West Third St. Los Angeles, CA 90048

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43851 Based on interview and record review, the facility failed to ensure two of three sampled residents (Residents 11 and 55) were provided with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN, a form issued in order to transfer financial liability to beneficiaries before the SNF provides an item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or is custodial in nature). This deficient practice had the potential to result in Resident 11 and Resident 55 not being given the information needed to make informed decisions about their care. Findings: a. A review of Resident 11's Admission Record indicated the facility admitted the resident on 4/19/2024 with diagnoses that included an unspecified fall, urinary tract infection (an infection in any part of the urinary system), hypertension (high blood pressure), muscle weakness, anxiety, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily living). A review of Resident 11's SNF Beneficiary Protection Notification Review indicated the resident's last covered Medicare Part A Skilled Services was 5/29/2024. The SNF Beneficiary Protect Notification Review form indicated the facility initiated the discharge form, Medicare Part A, when benefit days were not exhausted and indicated a SNF Beneficiary Protection Notification Review Notice of Medicare Non-Coverage (NOMNC) form was provided to the resident, but a SNF-ABN was not. b. A review of Resident 55's SNF Beneficiary Protection Notification Review indicated the facility admitted the resident on 3/27/2024 with diagnoses that included diverticulitis (inflammation of irregular bulging pouches in the wall of the large intestine), hyperlipidemia (high levels of cholesterol in the blood), difficulty in walking, dysphagia (difficulty swallowing), major depressive disorder, hypertension (high blood pressure), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 55's SNF Beneficiary Protection Notification Review indicated the resident's last covered Medicare Part A Skilled Services was 5/31/2024. The SNF Beneficiary Protect Notification Review form indicated the facility initiated the discharge form Medicare Part A when benefit days were not exhausted and indicated a SNF Beneficiary Protection Notification Review Notice of Medicare Non-Coverage (NOMNC) form was provided to the resident, but a SNF-ABN was not. During a concurrent interview and record review on 6/6/2024, Resident 11 and Resident 55's SNF Beneficiary Protection Notification Review forms were reviewed with the Assistant Business Office Manager (ABOM). The ABOM stated Resident 11 and Resident 55 did not exhaust SNF days and had benefit days remaining. The ABOM stated Resident 11 and Resident 55 were provided with a NOMNC. The ABOM stated they did not know what a SNF ABN was and the residents were not provided with a SNF ABN because they did not know it was supposed to be provided. The ABOM stated a SNF ABN was supposed to be provided along with the NOMNC. The ABOM stated residents were provided with a NOMNC/SNF ABN to know they have ability to appeal if they want to and know their Medicare days were almost over. The ABOM stated there was a potential for the residents to not have the ability to make informed decisions about their care if they were not provided with the appropriate notices. During an interview on 6/6/2024 at 11:34 AM, the Director of Nursing (DON) stated Resident 11 and Resident 55 should have been provided with a SNF ABN, not just a NOMNC. The DON stated if the proper notices were not provided there was a potential for the resident and family to not be informed about their care and not be aware that their Medicare part A days were almost finished. A review of the facility's policy and procedure titled, PB DB102 Advance Beneficiary Notice, revised 1/1/2024, indicated when required, the provider of record must use the most current version of the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form, which was designated for use by rehab agencies and group practices. A review of the Centers for Medicare and Medicaid Services document titled, Form Instructions Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN), indicated Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care was: not medically reasonable and necessary; or considered custodial. The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 43851 Based on observation, interview, and record review, the facility failed to follow up on missing eyeglasses for one of six sampled residents (Resident 13), after the resident informed facility staff the eyeglasses were missing. This deficient practice had the potential to for Resident 13 to not have her missing items replaced. Findings: A review of the Resident 13's Admission Record indicated the facility admitted the resident on 5/12/2023 with diagnoses that included Type II diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy, causing high levels of sugar in the blood), arthritis (inflammation and swelling in one or more joints), spinal stenosis (when the spaces in the bones of the spine become too small), and hyperlipidemia (high cholesterol levels in the blood). A review of Resident 13's Inventory of Personal Effects dated 5/12/2023, indicated the resident had one pair of eyewear. A review of Resident 13's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 5/11/2024, indicated the resident required set up or clean up assistance with eating and oral hygiene. The MDS indicated Resident 13 required partial / moderate assistance for toileting hygiene, shower / bathing self, upper body dressing, lower body dressing, putting on / taking off footwear, and personal hygiene. A review of the Progress Note dated 5/15/2024 at 2:20 PM, documented by Registered Nurse (RN) 2, indicated Resident 11 stated one side of their earring had gone missing. The note indicated Resident 13 also stated her eyeglasses went missing last week. The note indicated Resident 13 had a case but no eyeglasses and the Social Services Director was informed. A review of Resident 13's Social Service note dated 5/28/2024 at 11:35 AM, indicated the Social Services Assistant (SSA) spoke with the resident. The note indicated Resident 13 stated she lost an earring and was not sure where she lost it. The note indicated Resident 13 stated she remembered taking them off the night when she returned from Mother's Day dinner with family. The note indicated SSA explained to Resident 13 that a receipt for the earring was needed to send to corporate. The note indicated Resident 13 stated she would continue to look. The social services notes did not indicate documentation regarding Resident 13's missing eyeglasses. A review of the facility's Grievance/Concern Log dated 5/2024, did not indicate a concern about missing eyeglasses from Resident 13. During a concurrent observation and interview on 6/3/2024 at 10:24 AM, Resident 13 was observed lying in bed with an empty eyeglasses case at residents beside. Resident 13 stated she had a pair of eyeglasses that went missing about a week ago, she told social services, but they did not do anything about it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2024 at 10:17 AM, RN 2 stated Resident 13 told her on 5/19/2024 that they were missing one earring and the eyeglasses. RN 2 stated Resident 13 had their eye glass case but there were no glasses. RN 2 stated she informed the Social Services Director of Resident 13's missing earring and eyeglasses. During an interview on 6/5/2024 at 10:19 AM, the Social Services Director (SSD) stated he was informed of Resident 13's missing earring, but not about the resident's missing glasses. The SSD stated he did not see the note written by RN 2 regarding Resident 13's missing glasses. The SSD stated if the social services department gets information regarding missing items from staff or residents a theft/loss form was filled out with the details. The SSD stated the facility will look for the item, get everyone involved, and if not found the missing item would be replaced. The SSD stated he would submit information about missing items to administration for follow up with corporate. The SSD stated there was no theft/loss form filled out regarding Resident 13's missing eyeglasses. The SSD stated he would follow up with Resident 13 about their missing eyeglasses now. During an interview on 6/5/2024 at 10:53 AM, the Administrator stated she was not informed Resident 13 was missing eyeglasses. The Administrator stated she gave Resident 13 her number to inform her of any concerns but had not received any concerns about missing eyeglasses from the resident. The Administrator stated she would follow up with Resident 13 now. During an interview on 6/6/2024 at 11:32 AM, the Director of Nursing (DON) stated if staff were informed of missing items, staff should follow up. The DON stated staff should check around the facility first for the missing item, if not found, the facility should take the next steps to replacing the items, especially if the item was on the inventory list. The DON stated staff should have followed up regarding Resident 13's missing eyeglasses. The DON stated there was a potential for Resident 13 to not have their eyeglasses replaced. A review of the facility's policy and procedure titled, Resident's Personal Property, effective 8/25/2021, indicated personnel would identify and record the Resident belongings upon administration to a facility. The Resident will be allowed to use his/her personal belongings to the extent possible. Residents will be encouraged to send valuables home; however, a personal property lock box/area may be made available, and items can be stored in a secured area of the Facility. All items brought into the Facility will be listened on the Inventory of Personal Effects from and kept in the Resident clinical chart. Any additional items brought into the Facility after admission much be added to the list. The Resident and/or resident representative will be notified of the loss or breakage of personal items and advised if the loss or breakage will or will not be repaired at the Facility's expense. The policy indicated any loss of breakage of a Resident's personal item will be properly documented on the Theft/Loss form and/or Grievance form by the person receiving the report, and then referred to the Administrator. The Administrator or designee will investigate the lost item. If the investigation identifies misappropriation of Resident property, refer to Abuse Prohibition policy. The results of the investigation will be given to the Resident/family and documented. A copy of the report will be sent to the Administrator.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43851 Based on interview and record review, the facility failed to ensure a Notice of Transfer/Discharge Form was sent to the Office of the State Long-Term Care Ombudsman (representatives that assist the residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) for one of six sampled residents (Resident 8). This deficient practice had the potential to result in an unsafe discharge and/or denying the resident the right to appeal the discharge. Findings: A review of Resident 8's Admission Record, indicated the facility readmitted the resident on 1/11/2024 with diagnoses that included asthma (a condition in which your airways narrow and swell making breathing difficult), dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with doing every day activities), muscle weakness, acute respiratory failure (a disease or injury that happened quickly without much warning and affects your breathing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily living). A review of Resident 8's Notice of Transfer/Discharge Form dated 12/31/2023, indicated the resident was transferred/discharged to General Acute Care Hospital (GACH) 1 on 12/31/2023. The form indicated Resident 8's transfer was necessary for their welfare and indicated the resident's needs could not be met in the facility. The form indicated Resident 8's family member was notified of the resident's transfer/discharge from the facility. The form did not indicate it was sent to the Ombudsman. A review of Resident 8's History and Physical (H&P) from GACH 1 dated 1/1/2024 at 1:31 AM, indicated the resident was admitted to GACH 1 on 12/31/2023. The H&P indicated Resident 8 was brought in by ambulance from the facility due to hypoxemia (a low level of oxygen in the blood). A review of Resident 8's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 5/11/2024, indicated the resident had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 8 required partial/moderate assistance for eating and oral hygiene. The MDS indicated Resident 8 required substantial/maximal assistance for toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. The MDS further indicated Resident 8 was dependent on help for showering/bathing self and putting on/taking off footwear. During a concurrent interview and record review on 6/5/2024 at 8:45 AM, Resident 8's Notice of Transfer/Discharge Form dated 12/31/2024 was reviewed with Registered Nurse (RN) 2. RN 2 confirmed the form was not sent to the Ombudsman. RN 2 stated the Notice of Transfer/Discharge form was supposed to be faxed to the Ombudsman when a resident was transferred or discharged from the facility. RN 2 confirmed there was no indication the form was faxed to the Ombudsman in Resident 8's medical chart. RN 2 stated there was a potential for an inappropriate discharge if the Ombudsman was not notified of a resident's transfer / discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/6/2024 at 11:22 AM, Resident 8's Notice of Transfer/Discharge Form dated 12/31/2024 was reviewed with the Director of Nursing (DON). The DON stated the form did not indicate the transfer information was faxed to Ombudsman. The DON stated when a resident was transferred or discharged to the hospital the Ombudsman was informed. The DON stated if a resident was transferred to the hospital, the licensed nurses fax the transfer/discharge form to the Ombudsman. The DON stated the from should have been faxed to notify the Ombudsman of Resident 8's transfer. The DON stated there was a potential for the resident to have an unsafe discharge if the Ombudsman was not aware of the transfer. A review of the facility's policy and procedure titled, OPS404 Discharge and Transfer, revised 11/15/2022, indicated for unplanned, acute transfers for the patient must be permitted to return to the facility. Prior to the transfer, the patient and patient representative will be notified verbally followed by written notification using the Notice of Hospital Transfer or state specific transfer form. Copies of the notices for emergency transfers must also be sent to the Ombudsman, but they may be sent when practicable, such as in a list of patients on a monthly basis or per state requirements

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43851 Based on interview and record review, the facility failed to develop a person-centered care plan for Lexapro (a medication used to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily living]) for one of six sampled residents (Resident 27). This deficient practice had the potential for Resident 70 to not receive adequate and appropriate care. Findings: A review of the Resident 27's Admission Record indicated the facility readmitted the resident on 4/17/2024 with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and unspecified mental disorder (a diagnosis made when the healthcare provider doesn't specify a particular depressive disorder diagnosis). A review of Resident 27's Physician's Order dated 4/20/2024 indicated the resident was to receive Lexapro 5 milligrams (mg) by mouth one time a day for depression manifested by withdrawn behavior. A review of Resident 27's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/26/2024, indicated the resident had moderately impaired cognition (a problem with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident required set up to clean up assistance with eating, oral hygiene, and personal hygiene. The MDS indicated the resident required partial/moderate assistance for upper body dressing. The MDS indicated Resident 27 required substantial/maximal assistance for toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. A review of Resident 27's Psychiatry Progress Note dated 4/30/2024, indicated the resident had a history of anxiety (a feeling of fear, dread, and uneasiness) and major depressive disorder. A review of Resident 27's MAR dated 5/1/2024 - 5/31/2024, indicated the resident received 28 doses of Lexapro. A review of Resident 27's MAR dated 6/1/2024 - 6/30/2024, indicated the resident received 3 doses of Lexapro. A review of Resident 27's Care Plan, indicated there was no care plan initiated for Lexapro. During a concurrent interview and record review on 6/5/2024 at 8:17 AM, Resident 27's care plan was reviewed with Registered Nurse (RN) 2. RN 2 stated Resident 27 was taking 5 mg of Lexapro one time a day for depression but the resident did not have a care plan for Lexapro. RN 2 stated Resident 27 should have a care plan for Lexapro because it tells us about the care the resident needs. RN 2 stated there was potential for Resident 27 to not receive adequate care if a care plan was not developed for Lexapro. RN 2 stated, We need to know to monitor the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2024 at 11:24 AM, the Director of Nursing (DON) stated Resident 27 should have a care plan for Lexapro. The DON stated a care plan ensured the care the resident receives is correct. The DON stated there was potential for a resident who receives Lexapro to not receive adequate care if they do not have a care plan developed for the medication. A review of the facility's policy and procedure titled, OPS416 Person-Centered Care Plan, revised 10/24/2022, indicated a comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual, or significant change in status) and review and review the care plan after each assessment. Care plan includes measurable objectives and timetables to meet a patient's medical, nurse, nutrition, and mental and physiological needs that are identified in the comprehensive assessments. The purpose to attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. A comprehensive person-centered care plan must be developed for each patient and must describe the following: Services that are to be furnished; any services that would otherwise be required but are not provided due to the patient's exercise of rights, include the right to refuse treatment; any specialized services or specialized rehabilitative services the Center will provide as a result of PASRR recommendations. In consultation with the patient and the resident's representative (s): Goals for admission and desired outcomes, preference and potential for future discharge. The care plan will be customized to each individual patient's preferences and needs.

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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. 43851 Based on interview and record review, the facility failed to ensure two of six sampled residents (Resident 69 and Resident 80) received care and treatment in accordance with professional standards of practice by failing to: -Implement Physician's Orders in a timely manner for Resident 69's orthopedic consultation (a type of physician who treats conditions related to the musculoskeletal system). This failure resulted in the delay of physical therapy (PT-medical treatment used to restore standing, walking, and movement of different body parts) treatment for Resident 69. -Ensure staff followed up with the physician and obtain orders for Testosterone injections (treatment for individuals whose bodies do not make enough natural testosterone, a hormone that is responsible for many of the physical characteristics specific to adult males) for Resident 80. This deficient practice had the potential for Resident 80 to experience withdrawal (physical and mental symptoms that occur after stopping or reducing intake of a medication) symptoms of headache and nausea. Findings: a. A review of Resident 69's admission record indicated the facility admitted the resident on 1/5/2024, with diagnoses including fibromyalgia (widespread body pain and tiredness), muscle weakness, history of falling, and dorsalgia (back pain). A review of the Physical Therapy (PT) Progress Notes, dated on 4/11/2024, indicated that per the rehabilitative nurse assistant (RNA), Resident 69 refused PT since admission. The RNA educated Resident 69 on the benefits of PT and per Resident 69 she expressed frustration of not seeing an orthopedic doctor. The PT Progress Note indicated Resident 69 stated that she did not want to put any weight on her left leg. The RNA notified the RN supervisor of Resident 69's continued refusal of PT. A review of Resident 69's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 5/8/2024, indicated the resident had lower extremity impairment on both sides and needed moderate assistance with activities of daily living (ADL's; an individuals daily self-care activities). During an interview on 6/3/2024 at 10:50 AM, Resident 69 stated she requested to see an orthopedic physician because she had not been able to get up and walk since arriving to the facility. Resident 69 stated she had not started PT because she wanted an orthopedic physician to evaluate her first before starting any treatment, as she did not want to injure herself. Resident 69 stated she was frustrated and wanted to be able to walk again so she can go home. During an interview on 6/4/2024 at 12:05 PM, Licensed Vocational Nurse (LVN) 2 stated Resident 69 was seen by the primary care physician (MD) monthly, but the resident insisted on being seen by an orthopedic doctor. LVN 2 stated Resident 69 had refused PT because she did not want to put any weight on her left leg and that it was important for the resident to start PT as soon as possible, so she could start walking. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2024 at 3:11 PM, the Case Manager (CM) stated he started the position two months ago and was not endorsed by the previous CM of Resident 69's orthopedic consultation order. The CM stated the orthopedic consultation authorization was received on 5/1/2024 and the earliest available appointment for Resident 69 was for 6/6/2024. The CM stated he was not aware that the resident was refusing physical therapy because she was waiting to be seen by an orthopedic doctor. The CM stated he should have attempted to find a sooner appointment for Resident 69. During a concurrent interview and record review on 6/5/2024 at 9:44 AM with Registered Nurse (RN 2), Resident 69's Notice of Authorization of Services form, dated 3/28/2024 was reviewed. It indicated Resident 69's orthopedic consultation was authorized by the insurance on 3/28/2024 but was not carried out until 5/1/2024. RN 2 stated she was aware of the issues with the delay of the orthopedic consultation for Resident 69. During a concurrent interview and record review on 6/5/2024 at 9:45 AM with RN 2, Resident 69's physician's progress note, dated 3/27/2024 was reviewed. It indicated Resident 69's physician addressed the orthopedic consultation order with a RN but no follow up of orthopedic consultation was made. RN 2 stated the resident should have been seen earlier by the orthopedic doctor and therefore started PT. RN 2 was unsure as to what happened and what caused the delay. During a concurrent interview and record review on 6/5/2024 at 10:56 AM with Director of Nursing (DON), Resident 69's Notice of Authorization Services form dated 3/28/2024, was reviewed. It indicated Resident 69 had been assigned to an orthopedic physician. The DON stated if Resident 69 already had authorization from the insurance for an orthopedic physician, the resident should have been scheduled an appointment right away. The DON stated the order was not carried out in a timely manner and it caused a delay in the resident's treatment. b. A review of Resident 80's Internal Medical Hospitalist History and Physical Note from General Acute Care Hospital (GACH) 1 dated 3/14/2024 at 10:45 PM, indicated the resident was admitted to GACH 1 on 3/14/2024. The GACH 1 Note further indicated, Resident 80 was taking Testosterone Cypionate (an injectable form of testosterone that's used to treat low testosterone levels) 200 milligrams (mg) by intramuscular injection (a shot of medicine given into a muscle) every 14 days at home. A review of Resident 80's Admission Record indicated the facility admitted the resident on 4/19/2024 with diagnoses that included sepsis (a life-threatening emergency that happens when your body's response to an infection damages vital organs and often causes death), Type II diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy, causing high levels of sugar in the blood), muscle weakness, osteomyelitis (inflammation or swelling that occurs in the bone), asthma (a condition in which your airways narrow and swell making breathing difficult), hypertension (when the pressure in the blood vessels are too high), and hyperlipidemia (increased cholesterol levels in the blood). A review of Resident 80's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/23/2024, indicated the resident was cognitively intact (has the ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 80 required set up or clean up assistance with eating, personal hygiene, and oral hygiene. The MDS indicated Resident 80 required substantial/moderate assistance with toileting hygiene, upper body dressing, and lower body dressing. The MDS indicated Resident 80 was dependent on staff for putting on/taking off footwear. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 80's Physician's Orders indicated there were no orders for Testosterone injections. During an observation on 6/3/2024 at 10:41 AM, Resident 80 was observed lying in bed. During a concurrent interview, Resident 80 stated he was doing ok and that he was supposed to take testosterone injections but had not been taking them while being in the facility. Resident 80 stated two nurses were informed of this about a week ago, but nothing happened. During a concurrent interview and record review on 6/5/2024 at 10:28 AM, Licensed Vocational Nurse (LVN) 7 stated Resident 80 had informed another nurse on the night shift that the resident was taking testosterone at home. LVN 7 stated she saw this information on the communication board on point click care (PCC, an electronic health care record software). LVN 7 reviewed the communication board on PCC with the surveyor. The communication board showed a note dated 5/30/2024 at 10:46 PM that indicated Resident 80 stated he took Testosterone from his physician from GACH 1. The note indicated to please ask the physician in the morning if Resident 80 could get an order for Testosterone injections. LVN 7 stated she tried to follow up with Resident 80's physician on 5/31/2024 but stated the physician did not respond. LVN 7 stated she endorsed it to another nurse after her shift was over on 5/31/2024 but could not remember who the nurse was that she endorsed the information to. LVN 7 further stated Resident 80 did not currently have any orders for Testosterone injections and she would try contacting the Resident 80's physician again. LVN 7 stated if she was having difficulty reaching the resident's physician, she was supposed to notify the Director of Nursing (DON) and the Medical Director but indicated this was not done when she could not previously reach Resident 80's physician regarding the Testosterone injections. During an interview on 6/6/2024 at 10:57 AM, Resident 80 stated he took Testosterone 200 mg by injection every 2 weeks. Resident 80 stated he could not remember when their last dose of Testosterone was, but stated they knew they were almost due for the dose. Resident 80 stated they were feeling fine, but stated when they have withdrawal from the Testosterone, they get headaches and nausea. During an interview on 6/6/2024 at 11:28 AM, the DON stated Resident 80 was not currently taking Testosterone. The DON stated the licensed nurses should have followed up with Resident 80's physician for orders of Testosterone injections. The DON further stated if the resident's physician did not answer after a few attempts at contacting them, they should have notified the Medical Director. The DON stated residents who were coming from the hospital should have their medications reconciled with the physician. The DON stated there was a potential for Resident 80 to experience withdrawal symptoms if they were not receiving Testosterone injections as they normally would. A review of the facility's policy and procedure titled, OPS424 Medication Reconciliation, effective 9/1/2022 indicated the patient's medication orders will be reconciled at each transition of care. Medication reconciliation is the process of comparing a patient's existing medication orders to all of the previous medications the patient has been taking. The process involves obtaining and maintaining a complete and accurate list of current medication use across all healthcare settings. To ensure a complete an accurate list of current medications, medication reconciliation will be performed: when patient are admitted from home; when patients are admitted /readmitted from the hospital; whenever a patient transfers in or out or changes healthcare setting; and upon discharge. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy indicated for patients admitted from the hospital: Obtain and review copies of Medication Administration Records (MARs), Treatment Administration Records (TARs), transfer forms, and Physician Order Sheets (POS). Verify MAR/TAR information with transfer forms and POS if available. A medication history will be obtained for all patients and documented in the patient's medical record as soon as possible after admission .Once reconciled, medication orders will be obtained from the physician/APP and entered electronically into the medical record. A repeat reconciliation will be performed to compare hospital/home care discharge medication listing to current Center medication listing to MAR. Any discrepancies discovered during repeat reconciliation will be reported to the physician/APP. A review of the facility's policy and procedures (P&P) titled, Resident Rights Under Federal Law, revised 2/1/2023, indicated the resident has the right to be informed of, and participate in, his/her treatment, including the right to receive services and/or items included in the plan of care. A review of the facility's policy and procedure titled, OPS123 Medical Director Responsibilities, revised 8/15/2023 indicated the Center Medical Director helps the Center Identify, evaluate, and address/resolve medical and clinical concerns and issues that: affect patient care, medical care of quality of life; or are related to the provision of services by physicians and other licensed health care practitioners. The Center Medical Director identifies performance expectations and facilitates feedback to physicians and other health care practitioners regarding their performance and practices. When applicable the Medical Director will have discussion and intervene, as appropriate, with health care practitioners regarding medical care that is inconsistent with current standards of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44253 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 30) received care and services necessary to prevent accidents and falls by failing to provide a fall mat, per Resident 30's risk for fall care plan. This deficient practice placed the resident at increased risk for injury after a fall. Findings: A review of Resident 30's Admission Record (face sheet) indicated the facility admitted the resident on 12/27/2023, with diagnoses including traumatic subdural hematoma (collection of blood between the covering of the brain and the surface of the brain due to an injury to the head), dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and hearing loss. A review of Resident 30's At Risk for Falls care plan, developed 1/15/2024, indicated the resident had cognitive loss, lack of safety awareness and impaired mobility. The care plan indicated the goal was for Resident 30 to have no falls with injury. The care plan interventions included to arrange residents environment to enhance vision and maximize independence, place the bed in a low position and to place a fall mat. A review of Resident 30's Situation Background Assessment and Recommendation Form (SBAR - documentation of a complete assessment in response to a change in condition) dated 3/8/2024, indicated Resident 30 had an unwitnessed fall and the resident was found on the floor by facility staff. A review of Resident 30's Minimum Data Set (MDS- standardized assessment and care planning tool) dated 4/1/2024, indicated Resident 30's cognition was severely impaired. The MDS indicated Resident 30 required partial/moderate assistance with personal hygiene, toileting hygiene, showering, dressing upper body and oral hygiene. The MDS also indicated Resident 30 did not attempt to walk 10 feet due to his medical condition or for safety reasons and the resident has had one fall since his admission. A review of Resident 30's Physician's Progress Note, dated 5/27/2024, indicated the resident was unable to communicate and lacked capacity to make medical decisions. During an interview on 6/4/2024 at 11:06 AM Registered Nurse 1 (RN 1) stated Resident 30 had a fall on 3/8/2024. RN 1 stated Resident 30's head hit the bedrail during the fall and Resident 30 was transferred to a general acute care hospital (GACH). During a concurrent review of Resident 30's risk for fall care plan, RN 1 stated per the care plan, the facility was to provide a fall mat for Resident 30 to prevent injury following subsequent falls. During an observation on 6/4/2024 at 11:19 AM with Licensed Vocational Nurse (LVN) 1 at Resident 30's bedside, LVN 1 stated Resident did not have a fall mat beside his bed. LVN 1 sated Resident 30 was supposed to have a fall mat and the fall mat prevents or minimizes the risk of injury after a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 6/4/2024 at 12:01 PM, the Director of Nursing (DON) stated per Resident 30's weekly nursing documentation form dated 5/29/2024, Resident 30 was at risk for falls. During an interview on 6/6/2024 at 12:03 PM, the DON stated a care plan was to ensure the care the resident receive is correct. The fall mat was to prevent a higher-level injury. A review of the facility's policy and procedures (P&P) titled, Fall Management, reviewed 3/15/2024, indicated intervention to reduce risk for falls and minimize injury will be implemented as appropriate. The P&P also indicated staff will implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. A review of the facility's policy and procedure titled, OPS416 Person-Centered Care Plan, revised 10/24/2022, indicated a comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual, or significant change in status) and review and review the care plan after each assessment. Care plan includes measurable objectives and timetables to meet a patient's medical, nurse, nutrition, and mental and physiological needs that are identified in the comprehensive assessments. The purpose to attain or maintain the patient's highest practicable physical, mental and psychosocial well-being. A comprehensive person-centered care plan must be developed for each patient and must describe the following: Services that are to be furnished; any services that would otherwise be required but are not provided due to the patient's exercise of rights, include the right to refuse treatment. The care plan will be customized to each individual patient's preferences and needs.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 68), who was experiencing unplanned severe weight loss (greater than five [5] percent [% - unit of measure] in one month), received the care and services necessary to prevent severe weight loss. Facility staff did not input into the electronic chart Resident 68's weekly weights, nor implement the care plan interventions of a frozen nutritional treat every day at lunch. These deficient practices placed Resident 68 at risk for continued nutritional decline and weight loss. Findings: A review of Resident 68's Admission Record indicated the facility admitted the resident on 1/4/2024 with diagnoses including multiple sclerosis (MS, disabling disease of the brain and spinal cord that causes the nerves to deteriorate or become permanently damaged), adult failure to thrive (state of decline that may include weight loss, decreased appetite, poor nutrition, and inactivity) and schizophrenia (a serious mental disorder in which people interpret reality abnormally). A review of Resident 68's Nutritional Assessment, dated 1/8/2024, indicated the resident weighed 109 lbs on 1/4/2024. The Nutritional Assessment indicated the resident was at risk for future weight variance, and the resident's body mass index (BMI - medical screening tool that measures the ratio of your height to your weight to estimate the amount of body fat you have) indicated Resident 68 was underweight, as the hospital laboratory results suggested the resident was malnourished. The Nutritional Assessment indicated the nutritional plan included a 4 ounce (oz) frozen nutritional treat at lunch, supplements and for the resident to receive an Ensure (a type of nutrition drink that may help people who cannot get all the nutrients they need from foods and other drinks) every day with medication pass. A review of Resident 68's Nutritional Risk Care Plan developed on 1/8/2024 indicated the resident was at risk for weight loss due to a diagnoses of MS, failure to thrive, and due to the BMI indicating she was underweight. The care plan indicated the goal was to minimize further significant weight loss and the long-term goal was for the resident to reach the ideal body weight of 108 to 132 lbs. The interventions to prevent weight loss included to increase Ensure Plus to three times a day, extend weekly weight for four weeks and to provide a 4 oz frozen nutritional treat twice a day at lunch and dinner. A review of Resident 68's History and Physical (H&P), dated 1/20/2024, indicated the resident's appetite was in need of improvement and the resident had fluctuating capacity to make decisions. The H&P also indicated the plan of care was to monitor the resident's weight and for the resident to have a registered dietician (RD) consult. A review of Resident 68's Entry Minimum Data Set (MDS, a standardized assessment and care-planning tool) dated 1/22/2024, indicated the resident had moderate cognitive (ability to acquire and understand knowledge) impairment. The MDS indicated Resident 68's weight was 109 pounds (lbs). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of Resident 68's Nutritional assessment dated [DATE], Resident 68 weighed 97.1 lbs. on 3/13/2024. The Nutritional Assessment indicated the resident had an 11.9 lb weight loss which equated to 10.9% weight loss in one month. There was significant weight loss possibly due to multiple medical problems. The intervention section of the assessment indicated staff were to monitor weight, intake, and diet tolerance. A review of the Physician's Orders dated 4/7/2024 indicated the facility was to provide Resident 68 a 4 oz frozen nutritional treat twice a day, at lunch and dinner for 30 days. A review of the Physician's Orders dated 4/10/2024 indicated the facility was to weigh Resident 68 every Monday for 4 weeks. A review of Resident 68's Nutritional assessment dated [DATE], indicated Resident 68 current weight was 95 lbs. The Nutritional Assessment used the resident's weight on 4/2/2024. A review of Resident 68's Minimum Data Set (MDS, standardized assessment and care-planning tool) dated 4/22/2024, indicated the resident had severe cognitive (ability to acquire and understand knowledge) impairment. The MDS indicated Resident 68's weight was 94 lbs (a 15 lb weight loss [13.77%] in 3 months); the resident had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and the resident was not on a prescribed weight-loss regimen. A review of Resident Physician's Orders dated 5/17/2024 indicated the facility was to weigh Resident 68 weekly for four weeks until 6/17/2024. A review of Resident 68's Weights and Vitals Summary log, dated 6/4/2024, indicated Resident 68's weights were: 109 lbs. on 1/4/2024; 102 lbs on 1/22/2024 97.1 on 3/13/2024 95 lbs on 4/2/2024; and 94.5 lbs on 5/6/2024 A review of the Weight Summary indicated the last inputted weight was on 5/6/2024. A further review of the Weights and Vital Summary indicated there were no weekly weights inputted from 4/10/2024 (per the physician's order on 4/10/2024) nor the weekly weights inputted after 5/17/2024 (per the physician's order on 5/17/2024). During an observation in Resident 68's room and interview on 6/3/2024 at 12:54 PM, Resident 68 was observed eating her lunch. During a concurrent interview, Certified Nursing Assistant (CNA) 7 stated Resident 68 did not have a frozen treat on her lunch tray. CNA 7 stated she did not know if Resident 68 was to have a frozen treat as part of her care plan. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/2024 at 10:54 AM, Registered Nurse 1 (RN 1) reviewed Resident 68's weight log in the electronic chart. RN 1 stated the restorative nursing assistant (RNA) weighs the resident and the licensed vocational nurse (LVN) inputs the weights into the electronic record. RN 1 stated there was one weight inputted for the months of April and May 2024. RN 1 stated the weekly weights were not completed. RN 1 further stated that Resident 68's nutritional care plan included the intervention to provide a frozen treat at lunch and dinner. RN 1 stated it was important to complete the weekly weights and important to know for a resident with severe weight loss in order to know if our interventions for the weight loss are effective. During an interview on 6/4/2024 12:30 PM, the Director of Nursing (DON) stated Resident 68's weekly weights were completed by the RNA, however the weights were not inputted into the Resident 68's electronic chart. During an interview on 6/5/2024 at 10:55 AM, the Registered Dietician (RD 1) stated Resident 68 experienced significant weight loss and the facility was to weigh the resident weekly. RD 1 also stated if the frozen treat was not part of the menu for the day for the facility, Resident 68 did not receive the frozen treat. A review of the facility policy and procedures (P&P) titled, Weight Management, dated 8/25/2021, indicated nursing will be responsible for obtaining each individual's initial weight. This will be included in the initial nursing assessment and /or admission note, Minimum Data Set/Resident Assessment Instrument (MDS/RAI) for skilled nursing facilities and in the nutrition assessment. Initial and subsequent measurements for weight will also be documented on in the weight/Vital tab in PCC or tracked in the electronic medical record and /or computer database. The P&P also indicated weights will be obtained weekly for 4 weeks after admission. Subsequent weights will be obtained monthly unless physician's orders or an individual's condition warrants more frequent weight measurements.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44253 Based on interview and record review, the facility failed to perform staff competencies upon hire and/or annually for three of five sampled staff (Certified Nursing Assistant [CNA] 8, 10 and Licensed Vocational Nurse [LVN] 4). This deficient practice had the potential for residents to not receive the appropriate level of care needed affecting quality of care and potentially leading to resident harm. Findings: During a review on 6/6/2024 at 10:05 AM, employee files CNA 8, CNA 9, CNA 10, LVN 4, and Registered Nurse 2 (RN 2) were reviewed. CNA 8's employee file indicated the employee was hired on 11/30/2018. There were no competencies for the year 2023 available for review in CNA 8's employee file. CNA 10's employee file indicated the employee was hired on 6/6/2022. There were no competencies for the year 2023 available for review in CNA 9's employee file. LVN 4's employee file indicated the employee was hired on 2/14/2024. LVN 4's file indicated there was no employee competency completed upon hire. During an interview on 6/6/2024 at 10:34 AM, the Director of Staff Development (DSD) stated staff competencies were evaluated upon hire, annually and as needed and the staff's performance evaluations were kept in the employee's file. During a concurrent record review of CNA 8, CNA 10, LVN 4 files, the DSD stated there were no competencies for CNA 8, CNA 10 and LVN 4 available for review in their respective files. The DSD stated the Director of Nursing (DON) or a Registered Nurse Supervisor should have completed LVN 4's competency upon hire. The DSD stated competencies were important to ensure staff were doing safe practices. The DSD stated competencies for medication pass, eye drops, notifying physicians, personal protective equipment, Hoyer lifts were some competencies that should be checked. The DSD stated there was potential harm to residents if performance evaluations were not done. During an interview on 6/6/2024 at 11:52 AM, the DON stated competencies were completed upon hire, as needed and annually. The DON stated competencies were evaluate to ensure staff have the proper skills to take care of the residents. The DON stated if performance evaluations were completed, the certified nursing assistants or licensed vocational nurse might give the proper care to residents. A review of the facility's policy and procedure titled, Competency of Nursing Staff, revised 5/2019, indicated all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will demonstrate specific competencies ad skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. P&P also indicated facility and resident specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to obtain informed consent for psychotropic medication (drugs that act on the brain to alter mood and behavior) use for two of three sampled residents (Resident 67 and Resident 290) when the following occurred: -Resident 67 gave verbal consent for a Quetiapine (a medication used for schizophrenia; a disorder that affects a person's ability to think, feel, and behave clearly), despite not having the mental capacity to make his own medical decisions. -There was no physician (MD) signature on the psychotropic medication administration disclosure form (form given to the resident with the risks and benefits for psychotropic medications) for Resident 67 and Resident 290. These failures had the potential to result in Resident 67 and Resident 290 not being educated on the risks and benefits of their prescribed psychotropic medications. Findings: A review of Resident 67's admission record indicated the facility admitted the resident on 2/27/2024 with diagnoses that included schizophrenia, Parkinson's disease (a brain disorder that causes stiffness, and difficulty with balance and coordination), anxiety disorder, and bipolar disorder (a mental illness that causes unusual shifts in mood). A review of Resident 67's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 5/20/2024, indicated the resident had moderate impaired cognitive (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) skills for daily decision making. A review of Resident 67's history and physical (H&P), indicated the resident could make needs known but could not make medical decisions. A review of Resident 290's admission record indicated the facility admitted the resident on 5/29/2024 with diagnoses that included schizophrenia, Type II diabetes mellitus (when the body has trouble controlling blood sugar and using it for energy), and hypertension (when the pressure in your blood vessels is too high). A review of Resident 290's MDS dated [DATE], indicated the resident had no cognitive impairment. During an interview on 6/4/2024 at 11:28 AM with Resident 67, Resident 67 stated he was not sure what medications he takes. During an interview on 6/5/2024 at 9:35 AM, Registered Nurse (RN) 2 stated Resident 67 was confused most of the time and should not be making his own medical decisions. RN 2 also stated the resident should have a representative sign the psychotropic medication administration disclose form on his behalf. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2024 at 10:37 AM with DON, Resident 67's psychotropic medication administration disclosure form, dated on 2/27/2024 was reviewed. The psychotropic medication administration disclosure form indicated Resident 67 gave verbal consent for Quetiapine to a nurse and it was documented. The DON stated Resident 67's representative or whoever was listed as the first emergency contact should be signing all of Resident 67's forms, including the psychotropic medication administration disclosure form. The DON also stated that residents with impaired cognition should have a designated person who was responsible with signing consents because a resident with impaired cognition would not be able to fully comprehend their treatment plan. During an interview on 6/5/2024 at 11:52 AM with Resident 67's MD, the MD stated Resident 67 had episodes of confusion and seems to be declining in his mental capacity. The MD stated that he believed the resident should not be making his own medical decisions and the resident should have a representative make medical decisions. During a concurrent interview and record review on 6/4/2024 at 10:15 AM with RN 1, Resident 290's psychotropic medication administration disclosure form, undated, was reviewed. It did not indicate the MD signed the form. RN 1 stated the psychotropic medication administration disclosure form should have been signed, as the MD was at the facility. RN 1 stated the importance of the psychotropic medication administration disclosure form to be signed by the MD was to ensure the resident was informed and educated about their newly prescribed medications. During a concurrent interview and record review on 6/5/2024 at 10:02 AM with the Director of Nursing (DON), Resident 290's psychotropic medication administration disclosure form, undated, was reviewed. It did not indicate the MD signed the form. The DON stated the psychotropic medication administration disclosure form should be signed by the MD within 72 hours from the time the order was given or within 7 days if the ordering MD saw the resident while the resident was in the hospital. If the MD had not signed the form within that time frame, then medical records would call the MD and remind them to sign. When asked if there should be MD signature and she stated, yes. The DON stated without the informed consent being signed by MD, the resident was at risk for not being informed of the risks and benefits of the medication they were being prescribed. A review of the facility's policy and procedures (P&P) titled, Psychopharmacological Medication Use, revised 11/31/2011, indicated if the attending physician/prescriber of a resident in a SNF [skilled nursing facility] prescribed, orders, or increases and order for a psychotherapeutic medication for a resident, the physician/prescriber shall do the following: obtain informed consent of the resident for purposes of prescribing, ordering, or increasing an order for the medication, and obtain informed consent of the resident's authorized representative for purposes of prescribing, ordering, or increasing an order for the medication personally or via telecommunication. The policy indicated facility staff should verify that the prescribing physician obtained informed consent or refusal prior to the administration of psychotherapeutic medications. Documentation of the fact that informed consent has been obtained by the physician / prescriber for the administration of psychotherapeutic medications must be available in the resident's permanent medical record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49571 Based on interview and record review, the facility failed to ensure the nurses were rotating the insulin (a medication that regulates sugar in the blood) injection site for two of five sampled residents (Resident 21 and 75). This failure had the potential to result in bruising, pain, lipohypertrophy (a lump or accumulation of fatty tissue under skin), and/or localized cutaneous amyloidosis (-a condition caused by the buildup of abnormal proteins in the skin) to Residents 21 and 75. Findings: A review of Resident 21's medical records indicated the resident was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (a disease condition that affects the way the body produces and processes blood sugar), other diabetic kidney complications, long term use of insulin, and muscle wasting (a condition that causes a loss or thinning of muscle mass). A review of the Physician's Orders, dated 5/5/2024, indicated Resident 21 to receive 24 units of Humulin NPH (a type of intermediate-acting insulin) to be injected subcutaneously at bedtime for diabetic mellitus management and Humulin regular insulin (a type of short acting insulin) to be injected subcutaneously four times a day using a sliding scale (a variable dosage dependent on the resident's blood sugar level). A review of Resident 21's April and May 2024 medication administration record (MAR) indicated the resident was administered: a. Humulin NPH solution on: 4/23/2024 6:07 AM on the resident's right arm subcutaneously 4/23/2024 10:23 PM on the resident's right arm subcutaneously 5/2/2024 6:07 AM on the resident's right arm subcutaneously 5/2/2024 10:14 PM on the resident's right arm subcutaneously b. Humulin Regular solution on: 4/30/2024 6:17 AM on the resident's right arm subcutaneously 4/30/2024 11:33 AM on the resident's right arm subcutaneously 4/30/2024 5:58 PM on the resident's right arm subcutaneously 5/2/2024 12:33 PM on the resident's left arm subcutaneously 5/2/2024 7:46 PM on the resident's left arm subcutaneously (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/2/2024 10:14 PM on the resident's left arm subcutaneously According to a review of Resident 75's medical records, the resident was admitted in the facility on 12/11/2023 with diagnoses including muscle weakness and diabetes mellitus without complications. A review of Resident 75's Physician's Orders, dated 5/5/2024 indicated an order for Insulin Aspart (a rapid or fast-acting insulin) to be injected subcutaneously before meals and at bedtime using a sliding scale and an order for 17 units of Insulin Detemir (a long-acting insulin) to be injected subcutaneously at bedtime for management of diabetes mellitus. A review of Resident 75's April and May 2024 medication administration record (MAR) indicated the resident was administered: a. Humulin Aspart solution on: 4/4/2024 11:25 AM on the resident's right arm subcutaneously 4/4/2024 6:36 PM on the resident's right arm subcutaneously 4/4/2024 8:06 PM on the resident's right arm subcutaneously 5/3/24 11:22 AM on the resident's left arm subcutaneously 5/3/24 5:23 PM on the resident's left arm subcutaneously 5/3/24 9:05 PM on the resident's left arm subcutaneously b. Insulin Detemir solution on: 4/27/2024 9:36 PM on the resident's left arm subcutaneously 4/28/2024 10:23 PM on the resident's left arm subcutaneously 5/27/2024 8:28 PM on the resident's left arm subcutaneously 5/28/2024 9:18 PM on the resident's left arm subcutaneously 5/30/2024 8:53 PM on the resident's left arm subcutaneously During an interview on 6/5/2024 at 9:53 AM, Licensed Vocational Nurse (LVN) 1 stated it was the practice in the facility and professional standards of practice to rotate the subcutaneous injection sites to prevent pain, bruising, lipohypertrophy. The staff should check the last injection site record and ask the residents' preference. During an interview on 6/5/2024 at 10:12 AM with Resident 75 (via a language interpreter [Activities Director]), the resident stated the staff did not ask his preferred injection site for insulin. They just inject the medication without telling him. The resident stated he preferred to inject the insulin on his stomach. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/5/2024 at 10:15 AM with LVN 5, Resident 21 and 75's April and May 2024 MAR were reviewed. The MAR indicated Resident 21 and 75's insulin subcutaneous injections site was not being rotated. LVN 5 stated rotation of subcutaneous injection sites were standard practice and injecting insulin on the same site can cause harm by creating a mass accumulation under the skin. LVN 5 stated in addition the medication might not work as it was intended to. During a phone interview on 6/5/2024 at 3:43 PM, the Pharmacist (PharmD) stated it was standard practice to rotate medication injection sites. During an interview on 6/6/2024 at 11:15 AM, the Director of Nursing (DON) stated it was the expectations of the facility and standard practice to rotate insulin subcutaneous injection sites. A review of the insulin manufacturer's guide, dated 2022, indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis (a mass under the injection site).

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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** 44253 Based on observation, interview, and record review, the facility failed to remove and replace expired medication in one of two Medication Storage Rooms. This deficient practice had the potential to result in a resident receiving expired or the wrong medication. Findings: On [DATE] at 11:32 AM, during an inspection of the Medication Room located at Nursing Station B with Registered Nurse 1 (RN 1), an intravenous piggyback (IVPB- a small volume of solution, through an established primary infusion line Meropenem (a medication used for the treatment of bacterial infections) 500 milligrams (mg) with expiration date of [DATE] was observed in the medication refrigerator. During a concurrent interview, RN 1 stated the medication was expired and was for a discharged resident. RN 1 sated the expired bag of Meropenem should have been discarded when the resident was discharged or when the medication became expired. RN 1 further stated by not discarding the medication, there was the potential for a resident to receive expired medication. During an interview on [DATE] at 11:53 AM, the Director of Nursing (DON) stated medications should be removed when residents were discharged from the facility, when the medicine was discontinued or expired. The DON stated not discarding the medication could lead to the medication being given to the wrong resident and cause harm. A review of the facility's policy and procedure titled, 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, revised [DATE], indicated the facility should ensure medications and biologicals for expired or discharged residents were stored separately, away from use, until destroyed or returned to the provider. The policy indicated the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law, and in accordance with Policy 8.2 (Disposal/Destruction of Expired or Discontinued Medication).

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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. 46843 Based on observation, interview, and record review, the facility failed to ensure sanitary food storage practices in the kitchen freezer area for one of two freezer floor areas located in the kitchen. The kitchen had trash littered on the floor where the frozen food was kept for resident consumption. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of bacteria from one object to another) that could lead to foodborne illness in 80 of 80 medically compromised residents who received food from the kitchen. Findings: During initial tour observation of the kitchen on 6/3/2024 at 7:18 a.m., the freezer area revealed an unsanitary floor area located in a small compartment inside a larger freezer area. During an interview on 6/3/2024 at 12:23 PM, the Dietary Manager (DM) stated the freezer area should be cleaned and sanitized, and the floor should not be dirty with trash littered on the floor where the food was stored. The DM stated that she would provide an immediate in service for the staff on cleaning and maintaining a safe and clean environment in which to store the food that would be served to the residents at the facility. During an interview on 6/6/2024 at 11:58 a.m., the Director of Nursing (DON) stated the floor in the freezer area was not checked during the monthly walkthrough assessment of the kitchen area. The DON stated that a deep cleaning for the freezer area has been scheduled to ensure the freezer was clean and sanitized to prevent any possibility of cross contamination of resident food. A review of the facility's policy and procedure (P&P) titled, Environment, dated 9/2017, indicated all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The policy further indicated all trash will be contained in covered, leak-proof containers that prevent cross contamination.

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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** 44253 Based on interview and record review, the facility failed to ensure necessary care was consistently provided for one of 23 sampled residents (Resident 38), who received hospice service (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill), by failing to maintain an integrated hospice binder that included: -Calendar of hospice staff visits. -Certification of Terminal Illness. -Ensure that hospice staff provided nursing/visitation notes to the facility. -Specific and resident centered end stage/hospice care plan. These deficient practices had the potential to lead to the resident not receiving the needed and necessary services timely. Findings: A review of the admission record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, adult failure to thrive (state of decline that may include weight loss, decreased appetite, poor nutrition, and inactivity), moderate protein-calorie malnutrition (lack of proper nutrition) and major depressive disorder (characterized by a persistent feeling of sadness or a lack of interest in outside stimuli). A review of the hospice and facility contract, dated 1/20/2024, indicated the hospice agency will provide physician certifications and recertifications of terminal illness and hospice shall review hospice patients clinical records to determine if they include a record of all inpatient services. The contract indicated the hospice agency and the facility were responsible for documenting communications with one another in its respective clinical records to ensure the needs of the hospice patients were met 24 hours per day. A review of Resident 38's Patient Service Agreement with the hospice agency dated 1/22/2024, indicated the date of hospice election (hospice admitted) was 1/22/2024. A review of the Physician's Order Summary Report indicated on 2/23/2024 Resident 38 was admitted to the hospice agency. According to a review of Resident 38's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 4/24/2024, the resident had severely impaired cognitive skills for daily decision making and received hospice care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 38's Progress Notes, dated 5/25 and 5/26/2024 indicated Registered Nurse (RN) 2 attempted to reach Resident 38's hospice agency regarding lab results but the hospice agency could not be reached. When called it indicated, Call cannot be completed at this time try to call later. A review of Resident 38's medical records on 6/4/2024 at 10:17 AM, the hospice section indicated there was no Physician Certification of Terminal Illness. There were no progress notes from hospice staff and no calendar indicating the dates of visits for any month from January to June 2024. During an interview on 6/5/2024 at 8:47 AM, RN 2 stated Resident 38 was admitted to hospice on 1/22/2024 and was unaware of Resident 38's hospice diagnosis(es). During a concurrent review of Resident 38's hospice section of the physical chart, RN 2 stated there was no certification of terminal illness in the chart. RN 2 stated Resident 38's hospice care plan was not specific to Resident 38 as it did not include Resident 38's hospice diagnoses. The certification of terminal illness hospice staff comes once a week. RN 2 stated she could not find any calendar for the months of January to June 2024. When asked how do you know when the hospice will visit and how do you coordinate care, RN 2 stated she did not know when the hospice visits and RN 2 never coordinates care with the hospice. During a concurrent review of Resident 38's interdisciplinary team (IDT, - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide care for the residents) notes, RN 2 stated there was no evidence hospice staff attended the IDT meetings. RN 2 stated the IDT meeting was a collaborative meeting with all departments involved in Resident 38's care and the hospice should be involved to ensure proper care of the resident. During a concurrent interview and record review with the Director of Nursing (DON) on 6/5/2024 at 9:11 AM, Resident 38's hospice section of the physical medical chart was reviewed. The DON stated there was no certification of terminal illness in the chart and the DON called the hospice agency in order to receive a copy. The DON further stated there were no hospice progress notes in the chart. During an interview on 6/6/2024 at 12:05 PM, the DON stated the hospice chart was to contain the certification of terminal illness, hospice progress notes and hospice calendar. The DON stated the calendar was in the chart so that everyone had access to it and the facility was aware when the hospice staff was scheduled to visit. A review of the facility's policy and procedure titled, OPS118 Hospice, reviewed 1/13/2022, indicated the facility was responsible for ensuring the hospice services provided meet professional standards and principles and for the timeliness of those services. The policy indicated the hospice and facility must communicate, establish and agree upon a coordinated plan of care which reflects the hospice philosophy, and was based on an assessment of the patient's needs.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview and record review, the facility failed to ensure 14 of 33 resident rooms (room [ROOM NUMBER], 8, 9, 11, 14, 15, 16, 17, 18, 19, 21, 23, 24, 25) met the space requirements of 80 square feet for each resident in multiple resident bedrooms. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the impacted residents. Findings: On 6/3/2024 at 8:30 AM to 11 AM, during a general tour of the facility, Rooms 1, 8, 9, 11, 14, 15, 16, 17, 18, 19, 21, 23, 24, 25 were observed to not be occupied with more than four residents. The rooms were observed with enough space for nursing staff to provide care to the residents in the rooms. The rooms were observed with privacy curtains for each resident and with direct access to the corridors. During the resident council meeting (an organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care, and quality of life) on 6/4/2024 at 11 AM, there were no concerns brought up by residents who attended the meeting regarding the size of the residents' rooms. A review of the Client Accommodations Analysis dated 6/6/2024, indicated the following rooms with their corresponding measurements: Room # # of beds Total Square Feet 1 3 228.46 8 3 229.00 9 3 237.00 11 3 233.00 14 3 234.00 15 3 237.00 16 3 230.00 17 3 234.00 18 3 216.00 19 3 239.97 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	21 3 225.70 23 3 239.28 24 3 236.54 25 3 239.71 The Client Accommodation Analysis indicated the above rooms measured less than the required 80 square footage per resident in multiple resident bedrooms. For a three-bed capacity room, the square footage requirements would be at least 240 square feet. During a concurrent observation and interview on 6/6/2024 at 9:08 AM, Licensed Vocational Nurse (LVN) 2 was observed in room [ROOM NUMBER] administering medications. LVN 2 observed moving around resident bedside tables in the room easily. No obstructions were observed in LVN 2's way. LVN 2 stated she had no difficulty moving in the room. LVN 3 stated she felt like there was enough space in room [ROOM NUMBER] for her to work with the residents. During a concurrent observation and interview on 6/6/2024 at 9:17 AM, room [ROOM NUMBER] was observed with three residents. Resident 81 was observed in room [ROOM NUMBER] bed A with a walker and cane at bedside. Resident 81 was observed with a dresser and bedside table. No obstructions were observed in room [ROOM NUMBER]. Resident 86 stated they were able to get up out of bed and use their cane. Resident 86 stated they had no trouble getting around the room. Resident 86 was observed in bed B with a wheelchair at bedside, a dresser, and a bedside table. Resident 86 stated they were happy with the amount of space they had in their room. Resident 86 stated they used their wheelchair with the help from the nurses. Resident 86 stated the nurses have no problems with the space in their room. During an observation on 6/6/2024 at 9:27 AM, Certified Nursing Assistant (CNA) 4 was observed in room [ROOM NUMBER] assisting a resident in bed B to a shower chair. A wheelchair was also observed at the bedside of bed B. CNA 4 was observed being able to move around the room without difficulty. There were no projections or other obstructions observed that interfered with the movement of the shower chair around the room. A review of a letter from the Administrator dated 6/6/2024, indicated the Administrator was requesting a waiver for Rooms 1, 8, 9, 11, 14, 15, 16, 17, 18, 19, 21, 23, 24, 25. The letter indicated each room listed on the attached Client Accommodation Analysis had no projections or other obstruction, which may interfere with free movement of wheelchairs and/or sitting devices. The letter indicated there was enough space to provide for each resident's care, dignity, and privacy. The letter indicated the rooms were in accordance with the special needs of the residents and would not have an adverse effect on residents' health and safety or impede the ability of any residents in the rooms to attain his or her highest practicable well-being. The letter indicated all measures would be taken to assure the comfort of each resident. The letter further indicated the granting of this variance would not adversely affect the health and safety of the residents and would be in accordance with any special needs of each resident. The room waiver was recommended to continue and was contingent with federal regulations at accommodation of needs (483.15 e) and Resident Rights (483.10).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 43851 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of six sampled residents (Resident 8). This deficient practice had the potential to result in the resident not being able to call nursing staff for assistance when needed. Findings: A review of Resident 8's Admission Record, indicated the facility readmitted the resident on 1/11/2024 with diagnoses that included asthma (a condition in which your airways narrow and swell making breathing difficult), Parkinson's disease (a brain disorder that causes unintended or uncontrolled movements such as shaking), Type II diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy, causing high levels of sugar in the blood), dysphagia (difficulty swallowing), dementia (impaired ability to remember, think, or make decisions that interferes with doing every day activities), muscle weakness, acute respiratory failure (a disease or injury that happened quickly without much warning and affects your breathing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily living). A review of Resident 8's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 5/11/2024, indicated the resident had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 8 required partial/moderate assistance for eating and oral hygiene. The MDS indicated Resident 8 required substantial/maximal assistance for toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. The MDS further indicated Resident 8 was dependent on help for showering/bathing self and putting on/taking off footwear. During a concurrent observation and interview on 6/3/2024 at 8:42 AM, Resident 8 was observed lying in their bed on their right side. Resident 8 was observed with their call light hanging off the left side of the bed not within the resident's reach. The Infection Preventionist (IP) confirmed that Resident 8's call light was not within the resident's reach and stated the call light should be on the bed next to the resident, so it is easily reachable. The IP stated the call light should be within reach at all times so the resident can call for assistance if needed. During an interview on 6/6/2024 at 11:36 AM, the DON stated call lights should always be within the resident's reach. The DON further stated there was a potential for the resident to not get assistance or the care they need because they would not be able to call staff for help. A review of the facility's policy and procedure titled, NSG 101 Call Lights, reviewed 2/1/2023, indicated all patients would have a call light or alternative communication device within their reach at all times when unattended. Staff would respond to call lights and communication devices promptly.