STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055870	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunray Healthcare Center	3210 W Pico Blvd Los Angeles, CA 90019

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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 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** 49390 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for resident needs by not having the call light within reach for two of 22 sampled residents (Resident 13 and Resident 61) observed for call light placement. The deficient practice had the potential for residents not being able to call facility staff for help as needed. Findings: a. A review of Resident 13's Admission Record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including abnormalities of gait and mobility, muscle weakness, pressure-induced deep tissue damage (localized damage to the skin and/or underlying tissue usually over a bony prominence) of the sacral region, right and left heel, need for assistance with personal care, and history of falling. During a review of Resident 13's History and Physical (H&P) dated 3/31/2025, the H&P indicated the resident had the capacity to understand and make own medical decisions. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 3/21/2025, the MDS indicated the resident usually had the ability to understand others, and was missing some part of the message but comprehends most of the conversation. The MDS indicated the resident was dependent on toileting hygiene, was frequently incontinent of urine and always incontinent of bowel. The MDS also indicated Resident 13 had two unstageable pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence) presenting as deep tissue injuries that were present upon admission/entry or reentry. During a review of Resident 13's Care Plan titled, Resident has an ADL self care performance deficit related to limited mobility, initiated on 12/17/2024, indicated an intervention to encourage the resident to use bell to call for assistance. During a review of Resident 13's Care Plan titled, Resident at risk for falls with injury related to limited mobility and gait/balance problems, initiated on 12/17/2024, indicated interventions for the resident's call light to be within reach, encourage the resident to use it for assistance as needed and prompt response to all requests for assistance. The care plan also indicated interventions for the resident safe environment including a working and reachable call light. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 13's Care Plan titled, Resident bilateral upper 1/3 side rails up for turn and reposition, initiated on 12/17/2024, indicated interventions for call light within easy reach at all times and answer promptly. During a review of Resident 13's Care Plan titled, The resident had a communication problem related to a diagnosis of dysphagia oropharyngeal phase, initiated on 3/14/2025, indicated an intervention to encourage/provide a safe environment: call light in reach. During an observation on 4/21/2025 at 11:26 AM inside Resident 13's room, the call light was observed above the head resting on the mattress facing the back wall, not within reach of the resident. During a concurrent observation with the Director of Staff Development 2 (DSD 2), DSD 2 assisted the resident by placing the call light within reach and the resident requested to be changed after having an incontinent episode. DSD 2 contacted Certified Nursing Assistant (CNA) 8 to assist Resident 13. During an interview at 11:54 AM, CNA 8 stated that if the call light was not within reach the resident cannot call for assistance. b. A review of Resident 61's Admission Record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pressure ulcer of sacral region (sacrum- a large, triangular bone at the base of the spine) and right buttock, and functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to spinal cord injury). During a review of Resident 61's History and Physical (H&P) dated 4/2/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 61's MDS dated [DATE], the MDS indicated the resident usually had the ability to understand others, and was missing some part of the message but comprehends most of the conversation. The MDS indicated the resident was dependent on toileting hygiene, shower/bathe self, upper and lower body dressing including footwear and personal hygiene. The MDS also indicated the resident had one stage three (full-thickness loss of skin, dead and black tissue may be visible) and one stage four (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure ulcer injuries that were present upon admission/entry or reentry. A review of Resident 61's Care Plan titled, Resident has an ADL self care performance deficit related to hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), functional quadriplegia, initiated on 7/29/2023, indicated an intervention to encourage the resident to use bell to call for assistance. During a review of Resident 61's Care Plan titled, Resident has a behavioral problem of breaking the remote device related to repetitive pressing the call light, bed control and TV remote control, initiated /27/2024, indicated an intervention to frequently monitor, approach resident in calm manner, and stop resident actions of repetitive pressing call light. During a review of Resident 61' Care Plan titled, Resident at risk for unavoidable falls with injury related to limited mobility gait/balance problems. Surface-to-surface transfer (transfer between bed and chair or wheelchair = not steady, only able to stabilize with staff assistance), initiated on 8/9/2023, indicated an intervention to be sure the resident's call light was within reach and encourage resident to use it for assistance as needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/21/2025 at 11:41 AM inside Resident 61's room, the call light clipped to the top of the resident's mattress and left dangling off the side of the bed, not within reach of the resident. During an observation, DSD 2 assisted the resident by placing the call light within reach. During an interview at 11:53 AM, CNA 6 stated that if the call light was not within reach the resident cannot call for assistance. CNA 6 stated currently the assigned CNA for this resident was out for lunch but CNA's were always in the hallways checking and assisting the residents. During an interview on 4/24/2025 at 10:55 AM, the Director of Nursing (DON) stated that in the beginning of the shift, the nursing staff should be doing rounds to make sure the call lights were in place, this included the CNAs. During lunch time, there was a schedule for who was going to lunch. Those who stay behind take up their coworker's assignment until they return from their lunch. During an interview on 4/24/2025 at 10:59 AM, the DON stated having the call light within reach was important to be able to attend the resident's needs as soon as possible. During a review of the facility's policy and procedure titled, Answering the Call Light dated 8/30/2024, the P&P indicated to Ensure that the call light is accessible to the resident when in bed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49390 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 399) reviewed for Beneficiary Notification was provided with a Notice of Medicare Non-Coverage (NOMNC - a notice that is provided to beneficiaries that indicates when their Medicare covered services are ending). This deficient practice had the potential to result in the resident not being informed of their coverage end date and not being able to exercise their right to file an appeal. Findings: During a review of Resident 399's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] for an acute kidney failure (a condition where the kidneys suddenly lose their ability to filter waste products from the blood and regulate fluids and electrolytes in the body). The admission record indicated Resident 399 was discharged home on 12/23/2024. During a review of Resident 399's Minimum Data Set (MDS - a resident assessment tool) dated 11/17/2024, the MDS indicated Resident 399 was moderately cognitively (ability to think, understand, and reason) impaired. The MDS indicated Resident 399 needed partial assistance from another person to complete any activities such as self-care, mobility and functional cognition. The MDS further indicated Resident 399 required substantial/maximal assistance where helper does more than half the effort such as eating, oral hygiene, toileting, and upper body dressing. During review of Resident 399's SNF Beneficiary Notification Review form, the form indicated the resident's last covered day for Medicare Part A skilled services was on 12/23/2024. The form indicated the facility initiated the discharge from Medicare Part A Services when the benefit days were exhausted. The form indicated Resident 399 was not provided with a NOMNC. The form indicated the explanation for not issuing the NOMNC to Resident 399 as: not being able to locate the issued NOMNC and not being able to determine if beneficiary initiated discharge. During a concurrent interview and record review on 4/24/2025 at 1:06 PM, the Business Office Administrator (BOA) stated Resident 399's Medicare Part A skilled services started on 11/13/2024 when admitted to the facility and was discharged on [DATE]. The BOA stated Resident 399's discharge was planned and the resident went home with home health services. The BOA stated Resident 399's last covered day for Medicare Part A services was 12/23/2024 and was unable to locate the NOMNC. During a concurrent interview and record review on 4/24/2025 at 1:33 PM, the Director of Nursing (DON) stated they were unable to locate the 12/23/2024 issued NOMNC to Resident 399 and was not able to determine if it was a beneficiary initiated discharge. During a review of the facility's policy and procedure (P&P) titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, dated September 2022, the P&P indicated, If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) was issued to the resident at least two calendar days before benefits end.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on interview and record review, the facility failed to ensure three out of ten facilitiy staff (Registered Nurse [RN 1], Licensed Vocational Nurse [LVN 6], Certified Nurse Assistant (CNA 4) reviewed for personal file had a background check prior to employment. This deficient practice caused an increased risk to the safety of the residents. Findings: a. During a review of the facility document received to the Department dated 4/14/2025, the document indicated Resident 93 alerted the Administrator that CNA 4 handled her roughly during incontinent care on the morning shift. The document indicated CNA 4 was sent home and suspended pending investigation. During a review of Resident 93's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including need for assistance with personal care, gout (a form of arthritis, when uric acid crystals accumulate in the joints causing swelling and intense pain), and toxic encephalopathy (a disease or dysfunction of the brain, affecting its normal function). During a review of Resident 93's Minimum Data Set (MDS - a resident assessment tool) dated 4/1/2025, the MDS indicated the resident was oriented to year and month but not day, and had poor recall. The MDS indicated Resident 93 did not have little interest in doing things and did not feel down, depressed, or hopeless. During a review of the five-day abuse investigation conducted by the Administrator dated 4/14/2025, the investigation indicated an interview was conducted with CNA 4. CNA 4 stated Resident 93 was soiled and wet at the start of the shift. CNA 4 stated when she was ready to wash Resident 93, the resident was holding onto the curtain. She asked Resident 93 to release the curtain. CNA 4 stated she needed to turn Resident 93 side to side but the resident was resistant due to pain when being moved. On 4/22/2025 at 9:48 AM, a voice message was left for CNA 4 for a call back. As of 4/23/2025 no call back was received. During an observation on 4/21/2025 at 9:47 AM, in Resident 93's room, Resident 93 was lying in bed, with siderails x two, and with the call light within reach. During a concurrent interview, Resident 93 stated she asked a staff member for help, the staff member came in the room with an attitude, and started pulling on her while in the bed. Resident 93 stated she was holding onto the curtain and yelling because she did not want to fall. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/22/2025 at 12:25 PM, with the Director of Staff Development (DSD), two employee files were reviewed. CNA 4's employee file indicated the date of hire (DOH) was 10/5/2022, but the background check was done on 4/17/2024. The DSD stated they did a random background check for CNA 4 on 4/17/2024. The DSD stated she was still reviewing all the employee files to ensure all documents were in the files. The DSD agreed that if a staff member had an abuse allegation against them and there was not a background check performed before the hire date, then the staff member could be abusing residents without the facility's knowledge. During an interview on 4/24/2025 at 12:44 PM, the Director of Nursing (DON) stated there was a risk of danger to the residents when staff did not have a background check, because the facility would not know if the staff member had any abuse allegations against them. During a concurrent interview and record review on 4/23/2025 at 1:45 PM with the Director of Staff Development (DSD), two employee files were reviewed. RN 1's date of hire was 8/21/2014 while the background check was performed on 3/31/2025. The DSD stated the background check was a random check due to the original not in the file. LVN 6's hire date was 4/3/2025, and the background check was done on 4/23/2025. During a review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 4/2021, the P&P indicated the resident abuse, neglect, and exploitation prevention program consisted of a facility-wide commitment and resources including conducting employee background checks. During a review of the facility's P&P titled, Background Screening Investigations, dated 8/30/2024, the P&P indicated the director of personnel conducts the background checks, reference checks, and criminal conviction checks on all potential direct access employees and contractors. Background and criminal checks were initiated within two days of an offer of employment or contract agreement and completed prior to employment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50714 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 71) with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice. Resident 71 was not repositioned(turn from side to side) in her bed every two hours per the care plan. This deficient practice had the potential for Resident 71 to experience worsening of pressure ulcers (bedsores - areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body) / injuries to the resident. Findings: A review of Resident 71's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including acute (short-term) and chronic (long-term) respiratory failure (a serious condition that makes it difficult to breathe on your own), non-traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the thin tissues that cover it, without any prior head injury), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dependence on respiratory ventilator status (using a breathing machine to help them breathe), and persistent vegetative state (a person is awake but unaware of their surroundings and cannot interact with others). During a review of Resident 71's care plan, titled Pressure Ulcer: Altered skin integrity related to pressure ulcer on: Right Lower Leg lateral, Left lower leg lateral, Right scalp posterior (lateral), Right heel, Sacra coccyx, Wound on Right forearm, Outer Multiple wounds on Left Forearm Outer, dated [DATE] indicated a goal for the pressure ulcers/wounds to resolve without complications. The care plan intervention indicated to turn and reposition Resident 71 every two hours. A review of the Minimum Data Set (MDS, a resident assessment tool), dated [DATE], indicated Resident 71 was in a persistent vegetative state and was dependent on the facility staff for oral hygiene, toileting, showering/bathing, and rolling left and right. The MDS indicated Resident 71 was frequently incontinent of urine (unable to control when a person urinates) and always incontinent of bowel (unable to control when a person poops). The MDS also indicated Resident 71 had a Stage III and a Stage IV pressure ulcer (wound goes through all three layers of skin, exposing muscles, tendons [a cord of strong, flexible tissue, similar to a rope that attaches your muscles to your bones] and bones). A review of Resident 71's care plan titled, Functional abilities: dependent for all ADL (activities of daily living - basic tasks people do every day to take care of themselves)performance, dated [DATE] indicated the goal was for Resident 71 to receive adequate assistance. The care plan intervention indicated to assist Resident 71 to turn and reposition at least every two hours and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 71's Order Summary Report (OSR), dated [DATE], the OSR indicated Resident 71 had a diagnosis of pressure ulcer of other site, Stage IV, and pressure ulcer of sacral (a triangular-shaped bone located at the base of your spine, just below your lower back and above your tailbone) region. The OSR indicated an order for low air loss therapy mattress (a medical-grade mattress designed to prevent and treat pressure injuries by reducing moisture and heat buildup) for wound management. During an observation on [DATE] at 10:55 AM, Resident 71 was observed laying on her left side. During a concurrent observation and interview on [DATE] at 12:55 PM (two hours later) with Certified Nursing Assistant (CNA) 1 in Resident 71's room, Resident 71 was observed laying on her left side. CNA 1 stated he would reposition Resident 71 right away. CNA 1 stated Resident 71 would be at risk for a pressure ulcer if she was not turned/repositioned every two hours. During an interview on [DATE] at 1:07 PM, Licensed Vocational Nurse (LVN) 1 and the Registered Nurse Supervisor (RN) 1 stated residents should be repositioned every two hours to prevent pressure ulcers or worsening or pressure ulcers. During an interview on [DATE] at 2:16 PM, the Medical Director (MDR) stated Resident 71 obtained the ulcers from the general acute care hospital and that Resident 71 was close to skin failure (the skin has broken down or died , often due to poor blood flow and other underlying medical issues). During an observation on [DATE] at 2:43 PM with the Director of Nursing (DON) and CNA 2 in Resident 71's room, Resident 71 was observed to be lying on her left side (over three and a half hours). During a concurrent interview, the DON stated Resident 71 should have been turned every two hours and as needed. The DON reviewed and verified Resident 71's care plan titled, Functional abilities: dependent for all ADL performance, indicated an intervention to turn Resident 71 every two hours and as needed. During a concurrent interview, CNA 2 stated he and the Treatment Nurse (TX) repositioned Resident 71 after CNA 2 and the TX had performed Resident 71's dressing change. The DON verified Resident 71 remained lying on her left side. The DON agreed that placing a second pillow underneath Resident 71 did not mean she was repositioned, because the resident continued lying on the same side. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, dated [DATE], indicated the purpose of the P&P was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The P&P indicated the facility would reposition all residents with or at risk of pressure injuries. During a review of the facility's P&P titled, Repositioning, dated [DATE], indicated the purpose was to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. The P&P indicated frequency of repositioning a bed- or chair-bound resident should be determined by: a. The type of support surface used; b. The condition of the skin; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The overall condition of the resident; d. The response to the current repositioning schedule; and e. Overall treatment objectives. The P&P indicated residents should be on at least an every two-hour repositioning schedule.

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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** 49390 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of three sampled residents (Resident 29 and Resident 63) observed for respiratory care. For Resident 29 and Resident 63, the oxygen tubing was resting on the floor while connected to the residents' ventilators (a medical device to help support or replace breathing). This deficient practice had the potential for Resident 29 and Resident 63 to experience respiratory infections associated with using an unsanitary (dirty, unhealthy, or unclean in a way that could endanger health) oxygen tubing. Findings: a. A review of Resident 29's Admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses including chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (unable to get enough oxygen into your blood, leading to a dangerously low level of oxygen in your body) or hypercapnia (body cannot get rid of carbon dioxide [gas we naturally produce and need to remove when our bodies use oxygen for energy] causing breathing difficulties due to the buildup of carbon dioxide), cerebral infarction (stroke -a loss of blood flow to a part of the brain), and tracheostomy (a surgical procedure that creates an opening through the front of the neck for breathing). A review of Resident 29's History and Physical (H&P) dated 3/26/2025, indicated the resident had respiratory failure and was admitted under hospice care (a type of medical care that provides comfort and support to those nearing the end of their life). A review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 3/31/2025, indicated the resident was in a persistent vegetative state (a person is awake but unaware of their surroundings and cannot interact with others). During a review of Resident 29's Care Plan titled, Tracheostomy related to impaired breathing mechanics, injury, dated 4/16/2025, indicated a goal for Resident 29 to be free of signs and symptoms of infection. During an observation on 4/21/2025 at 9:37 AM in Resident 29's room, the oxygen tubing was observed touching the floor. During a review of Resident 29's Order Summary Report (OSR), dated 4/24/2025, the OSR indicated the resident had a physician's order for a tracheostomy tube, oxygen at four liters per minute via T-piece (a T-shaped connector tube used in to help patients who are having trouble breathing on their own or to support breathing), and titrate (adjust) oxygen to keep Resident 29's oxygen saturation (a measure of how much oxygen is carried by red blood cells in your blood, expressed as a percentage) above 94 percent. 50714 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A review of Resident 63's Admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses including dependence on respiratory ventilator, chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), chronic respiratory failure with hypoxia or hypercapnia ,and amyotrophic lateral sclerosis (ALS - also known as Lou Gehrigsdisease is a disease that affects nerve cells in the brain and spine). A review of Resident 63's H&P dated 11/24/2024, indicated Resident 63 was on a ventilator with tracheostomy and had mental capacity (a person's ability to understand information and make decisions for themselves). During a review of Resident 63's care plan titled, Ventilator dependent related to respiratory failure dated 2/20/2025, indicated a goal for Resident 63 to be free of ventilator associated pneumonia (an infection / inflammation in the lungs). During a review of Resident 63's care plan titled, Tracheostomy related to injury, dated 2/20/2025, indicated a goal for Resident 63 to have no signs and symptoms of infection. A review of Resident 63's MDS, dated [DATE], indicated Resident 63 usually had the ability to understand others and make himself understood. During a review of Resident 63's OSR dated 4/22/2025, the OSR indicated the resident had a physician's order for a trach tube, ventilator, oxygen at 2.5 liters per minute via oxygen concentrator (a medical device that gives you extra oxygen), and titrate (adjust) oxygen to keep Resident 63's oxygen saturation above 94 percent. During an observation on 4/21/2025 at 9:37 AM in Resident 63's room, the oxygen tubing was observed touching the floor. During a concurrent observation and interview on 4/21/2025 9:46 AM with Respiratory Therapist (RT) 1 in both resident's room, the oxygen tubing for Resident 63 and Resident 29 were observed touching the floor. RT 1 stated the tubing for Resident 63 and Resident 29 was on the floor and would exchange them for new ones. RT 1 stated oxygen tubing on the floor could be an infection control (preventing the spread of infections, especially in healthcare settings) problem for Resident 63 and Resident 29. During an interview on 4/22/2025 at 2:41 PM with the Infection Preventionist (IP) and Director of Nursing (DON), both the IP and DON stated oxygen tubing touching the floor would be an infection control issue. A review of the facility's policy and procedure titled, Policies and Practices - Infection Control, dated 8/30/2024 indicated, 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. The objectives of the facility's infection control policies and practices were to prevent, detect, investigate and control infections in the facility. The P&P indicated all personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure safe medication administration and accurate accountability of controlled medications (high potential for abuse) as indicated in the facility's policy and procedures (P&P) for four of four sampled residents (Resident 6, Resident 18, Resident 73, and Resident 80) observed during the medication administration by failing to: -Ensure Resident 80's blood pressure (BP) medication, Amlodipine 5 milligram ([mg] - a unit of measure for weight) was administered as ordered and the physician was notified when administered over an hour later than the 9 AM scheduled administration six times, between 4/7 to 4/21/2025. (Cross Reference F759) -Ensure the Controlled Drug Record form (CDR, an accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Record (MAR, a log initialed and/or signed by the nurse with the date and time each time a medication is administered to a resident) for an administered dose of a controlled medication, (Oxycodone/acetaminophen [APAP] is a combination medicine used to help treat severe pain) 10 mg per 325 mg [10-325 mg] on 3/28/2025 at 8:20 PM for Resident 80. -Ensure an accurate accountability of the inventory of a controlled medication Ativan (Lorazepam, use to treat seizures, a sudden, temporary disruption of normal brain activity) 20 mg per 10 milliliter (ml, unit of measurement by volume) was maintained at all times including delivery to the facility and administration of the medication to Resident 18. -Ensure Resident 18 was reassessed for effectiveness of as needed (PRN) when administered Ativan for seizure control within 30 minutes and not over 15 hours later. -Ensure the prescription label, the Medication Administration Record (MAR) and the current physician's order matched for Resident 18's controlled medication, Ativan. -Ensure Resident 6 and Resident 73 had rotation of injection sites for insulin administration. These deficient practices had the potential for discoloration of skin and hardening of the injection sites for Resident 6 and Resident 73, created the potential for unsafe medication administration of necessary medications to Resident 80 and Resident 18, had the potential for inability to readily identify loss and drug diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of controlled medications, and resulted in an increased risk for inaccurate reconciliation of controlled medications in the facility. Findings: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A review of Resident 80's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertension (HTN, high blood pressure), dependence on respiratory (ventilator, relies on a machine to breathe and cannot breathe independently) status, and gastrotomy tube (G-tube, a surgically placed tube that provides direct access to the stomach for feeding, hydration, or medication administration). During a review of Resident 80's Minimum Data Set (MDS - a resident assessment tool) dated 3/27/2025 indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) was intact and the resident required between moderate to totally dependent on staff for activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a medication pass observation on 4/21/2025, between 11:33 AM to 12:14 PM for Resident 80, with Licensed Vocational Nurse (LVN) 2, LVN 2 was observed preparing and administering one tablet of Amlodipine 5 mg crushed, dissolved in water and given through a G-tube to the resident. LVN 2 was not observed checking Resident 80's BP prior to the administration of the BP medication. During an interview on 4/21/2025 at 12:20 PM, LVN 2 stated there was a timeframe to give medications and Resident 80's scheduled 9 AM medications was to be administered by 10 AM. LVN 2 stated, I have not notified my supervisor that I was running behind, and I have not called or informed the doctor yet. LVN 2 stated the Registered Nurse Practitioner (NP 1) was at the facility and had not been notified. During an interview on 4/21/2025 at 12:39 PM, LVN 2 stated she checked Resident 80's BP at 8:04 AM, on 4/21/2025 at the start of her shift, but had not checked Resident 80's BP before administering the resident's BP medication, Amlodipine at 12:19 PM (four hours later). A review of Resident 80's April 2025 Physician's Order Summary Report indicated: -Amlodipine Oral Tablet 5 mg, dated 12/23/2024, give one tablet via G-Tube one time a day (scheduled administration at 9 AM) for hypertension. Hold for systolic blood pressure (SBP, when the heart contracts and pumps blood) less than 110 millimeters of mercury (mmHg) or heart rate (HR, the number of times the heart beats per minute [bpm]) less than 60 bpm. -Metoprolol Tartrate 50 mg, dated 12/23/2024, give one tablet via G-tube every eight hours (scheduled administration at 6 AM, 2 PM, and 10 PM) for HTN. Hold for SBP less than 110 mm Hg or HR less than 60 bpm. During a review of Resident 80's Medication Administration Audit Report dated between 4/7/2025 to 4/21/2025, indicated the resident was administered Amlodipine scheduled daily at 9 AM late on a total of six occasions as follow: 4/12/25 scheduled at 9 am, documented administered at 11:06 am 4/13/25 scheduled at 9 am, documented administered at 12:58 pm 4/14/25 scheduled at 9 am, documented administered at 11:16 am (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/17/25 scheduled at 9 am, documented administered at 12:04 pm 4/19/25 scheduled at 9 am, documented administered at 10:38 am 4/21/25 scheduled at 9 am, documented administered at 12:19 pm During a concurrent interview and record review on 4/21/2025 at 3:56 PM, with the Director of Nursing (DON), Resident 80's April 2025 Physician's Orders was reviewed and indicated resident's Metoprolol Tartrate 50 mg, had a 2 PM scheduled administration time. The DON stated if another medication was due soon after the late medication (Amlodipine) was administered, there could be an overlap of BP medications and the effect of the combined BP medications could have a greater effect on the resident that could lead to a confusion, lethargy (sleepiness), or a stroke (occurs when blood flow to the brain is interrupted). The DON stated if medications were not given as scheduled, the physician should be notified. During an interview on 4/23/2025, at 2:41 PM, the facility's Medical Director (MDR) stated the physician should have been informed if Resident 80 received medications later than scheduled. The MDR stated the reason for checking the resident's BP before giving the BP medication was to ensure the licensed nurse follows the parameters that were listed on the physician's order. During a review of the facility's P&P titled, Administering Medications, revision date 4/2019 indicated medications were administered in a safe and timely manner, and as prescribed. Staffing schedules were arranged to ensure that medications were administered without unnecessary interruptions. Medications were administered in accordance with prescriber orders, including any required time frame. Medications were administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The following information was checked / verified for each resident prior to administering medications .Vital signs if necessary. b. A review of Subacute A, Medication Cart 3, on 4/23/2025 at 10:13 AM, with LVN 4, indicated Resident 80's CDR for Oxycodone/APAP 10-325 mg had one tablet removed from the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication) on 3/28/2025 at 8:20 PM. The MAR indicated the licensed nurse's initials or documentation to indicate the resident was administered the dose of Oxycodone/APAP 10-325 mg on 3/28/2025 at 8:20 PM was missing. During a concurrent interview, LVN 4 stated Resident 80's administration of Oxycodone / APAP 10-325 mg was not documented on the MAR on 3/28/2025, but was documented on the CDR on 3/28/2025 at 8:20 PM. LVN 4 stated when the licensed nurse removed the Oxycodone/APAP 10-325 mg from the medication card for Resident 80, the nurse should have signed on the CDR for the removal of the medication and signed on the MAR after the medication was administered to the resident. During a review of Resident 80's March 2025 Physician's Order Summary Report, the report indicated a physician's order for Oxycodone/APAP Oral Tablet 10-325 mg, with instructions to give one tablet via G-Tube every 8 hours as needed for moderate to severe pain 4-10 (using a Pain Scale of 0-10, 0 indicating no pain and 10 indicating most severe pain). The report indicated to hold if drowsy or respiratory rate (RR, the number of breaths a person takes per minute) below 12 and notify MD (physician). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/23/2025 at 11:18 AM, with Licensed Vocational / Quality Assurance Nurse (LVN 5), Resident 80's pain assessment, MAR, CDR, and nursing progress notes were reviewed. LVN 5 stated the initials on the CDR was from a Registry (temporary nurse) LVN (LVN 6). LVN 5 stated LVN 6 did not document on Resident 80's MAR the administration of Oxycodone/APAP 10-325 mg and did not document on the MAR or in the nursing progress notes a pain assessment for the resident to determine the resident's level of pain prior to administering the pain medication or the effectiveness of the medication. LVN 5 stated not documenting on the MAR increased the risk for medication errors and drug (medication) diversion. During an interview on 4/23/2025 at 3:01 PM, the facility's Medical Director (MDR) stated licensed nurses should have documented the administration of Oxycodone/APAP 10-325 mg for Resident 80 on the MAR to verify that the medication was pulled and administered to the resident. During a review of the facility's undated policy and procedure (P&P) titled, Documentation of Medication Administration, the P&P indicated A medication administration record is used to document all medications administered. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's MAR. Administration of medication was documented immediately after it was given. Documentation of medication administration includes, as a minimum, initials, signature and title of the person administering the medication, resident response to the medication, if applicable (e.g., PRN, pain medication, etc.). c. During a review of Resident 18's Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included epilepsy (a brain condition that causes repeated seizures), anoxic brain damage (brain injury resulting from a complete lack of oxygen supply, causing serious damage or death to brain cells), dependence on respiratory (ventilator), and G-Tube A review of Resident 18's MDS dated [DATE] indicated the resident was in a persistent vegetative state (PVS, an individual with severe brain damage appears to be awake but shows no evidence of awareness of their surroundings). Resident 18's MDS indicated the resident was totally dependent on staff for activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During concurrent interview and record review of Subacute A, Medication Cart 3, on 4/23/2025 at 10:20 AM, with LVN 4, Resident 18's CDR, MAR, Medication Administration Detail, physician's order, and pharmacy label for Resident 18's Ativan 2 mg/ ml injectable medication were reviewed, and the following discrepancies were observed: -Resident 18's CDR was handwritten that included the resident's name, the name of the medication, Ativan injection solution 2 mg/ ml, the route of administration, IM, and a starting quantity of 7 ml and an ending quantity of 6 ml. LVN 4 stated the instructions on the CDR form for Resident 18's Ativan was missing instructions for use and the pharmacist prescription label. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 18's Medication Administration Detail, for April 2025 indicated the resident was administered two doses of Ativan 2 mg/ml, injection of 0.5 ml (1 mg) on 4/12/2025 at 4:30 PM and follow up on 4/12/2025 at 4:32 documentation indicated, Effective and on 4/12/2025 at 4:41 PM and follow up on 4/13/2025 at 7:56 AM documentation indicated, Effective (15 hours later). LVN 4 stated Resident 18 should have been reassessed 30 minutes after the PRN administration of Ativan and not the next day. LVN 4 stated part of the documentation within 30 minutes is to monitor the effectiveness of the medication administered to Resident 18 for seizure control. -Resident 18's April 2025 Physician's Order Summary Report included a physician's order for Ativan (Lorazepam) Injection Solution 2 mg/ml, instructions indicated to inject 0.5 ml (1 mg) intramuscularly (medication administered into a muscle) every 10 minutes as needed for seizure activity, order dated 4/8/2025. LVN 4 stated Resident 18's physician's order was missing a maximum dose. LVN 4 stated the physician's order was incomplete and the licensed nurse should have called the doctor to have the order for Ativan clarified. LVN 4 stated Resident 18's Ativan, physician's order was missing the maximum dose to give before calling the physician. LVN 4 stated Resident 18 was receiving Ativan for seizures, if the medication was not effective for the seizures the resident would need to be sent out by calling 911 (an emergency situation that requires immediate assistance from the police, fire department or ambulance) and transfer to the hospital for uncontrolled seizures. LVN 4 stated there was nothing on the order to indicated when to call the physician. -Resident 18's Ativan prescription label dated 8/26/2024, instructions for use indicated to administer 1 ml (2 mg) of Ativan 2 mg/ ml every 10 minutes as needed for seizure disorder. LVN 4 stated the Ativan prescription labeled for Resident 18's was incorrect, and the current physician's order dose had decreased to 0.5 ml (1 mg) of Ativan 2 mg/ ml every 10 minutes as needed. The Ativan prescription bottle indicated 2 mg/ml quantity of 10 ml. The CDR indicated a starting quantity of 7 ml. LVN 4 could not explain the 3 ml discrepancy in quantity of the controlled medication, Ativan 2 mg/ml. During a concurrent interview and record review on 4/23/2024 at 11:48 AM, with NP 1, Resident 18's April 2025, CDR, MAR, and nursing progress notes were reviewed. NP 1 stated Resident 18's licensed nurse should have documented the follow-up 30 minutes after the PRN dose of Ativan was administered by injection to Resident 18. NP 1 stated the reassessment of Resident 18 was to check if the resident was having another seizure that may require the facility to call 911 and send the resident out to the hospital to prevent a delay in care for seizure control. During an interview on 4/23/2024 at 11:55 AM, LVN 5 stated Resident 18's Ativan 2 mg/ml 10 ml vial had not been updated from the old instructions to administer Ativan 1 ml (2 mg) to the current order to administer Ativan 0.5 ml (1 mg), which could lead to medication errors or drug diversion. During an interview on 4/23/2025 at 1:12 PM, NP 1 stated Resident 18's Ativan 2 gm/ml order should have been clarified, and a new prescription should have been sent to the facility, or a note should have been attached to the prescription label to indicate a direction change with clear instructions for use. During an interview on 4/23/2025 at 3:12 PM, the MDR stated for Resident 18's Ativan 2 mg/ml the order should have been clarified to indicate how many doses to give and when to call the doctor and or call 911, because treatment may change. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Controlled Medication Storage, effective date 8/2014, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. A controlled medication accountability record was prepared by the pharmacy or facility for all Schedule II-V medications. The following information was completed: 1) Name of resident 2) Prescription number 3) Name, strength, and dosage form of medication 4) Date received 5) Quantity received 6) Name of person receiving medication supply 7) Dispensing pharmacy information . Any discrepancy in controlled substance medication counts was reported to the director of nursing immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. The director of nursing in conjunction with consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during medication storage inspections. d. A review of Resident 6's Admission Record indicated the resident was admitted to the facility on [DATE] with a diagnoses including Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), anoxic brain damage (a type of brain injury that occurs when the brain is completely deprived of oxygen), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 6's MDS dated [DATE], the MDS indicated the resident was not oriented to person, place, or time. The MDS indicated Resident 6 had poor recall and was either dependent and needed substantial/maximal assistance with eating, dressing, hygiene, showering, and toileting. During a review of Resident 6's Diabetes Mellitus Care Plan dated 4/2/2025, the Care Plan indicated in the interventions to rotate the injections sites. During a review of Resident 6's Location of Administration Record dated 4/2025, the Administration Record indicated Resident 6 received Novolin R injection in the same injection sites on the following dates: -4/2/2025 - subcutaneously (situated or applied under the skin) - Abdomen left upper quadrant (LUQ - located on the left side of the abdomen, above the navel), at 4 PM and 9 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/7/2025 - subcutaneously - Abdomen right upper quadrant (RUQ - located on the right-side abdomen, above the navel), at 11:30 AM and 4:30 PM. -4/11/2025 and 4/12/2025 - subcutaneously - Abdomen left lower quadrant (LLQ - located on the left side of the abdomen, below the navel). -4/19/2025 - subcutaneously - Abdomen LLQ at 12:22 PM and 11:01 PM. e. During a review of Resident 73's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with a diagnoses including Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 73's MDS dated [DATE], the MDS indicated the resident was oriented to year and month. The MDS indicated Resident 73 had poor recall and had no symptoms of feeling down, depressed, or hopeless. During a review of Resident 73's Location of Administration Record dated 4/2025, the Administration Record indicated Resident 73 received Insulin Injection in the same injection sites on the following dates: -4/6/2025 - subcutaneously - Abdomen LLQ at 05:32 AM and 12:22 PM. -4/11/2025 and 4/12/2025 - subcutaneously - Abdomen LLQ. -4/13/2025 - subcutaneously - Arm right at 11:37 AM and 5:34 PM. -4/13/2025 and 4/14/2025 - subcutaneously - Abdomen LUQ. -4/16/2025 - subcutaneously - Abdomen LUQ at 05:48 AM and 12:20 PM. -4/19/2025 - subcutaneously - Arm - right at 11:11 AM and 8:20 PM. -4/20/2025 - subcutaneously - Abdomen LLQ at 4:30 PM and 11:01 PM. -4/21/2025 - subcutaneously - Abdomen LLQ at 05:41 AM. During a concurrent interview and record review on 4/23/2025 at 12:15 PM with LVN 3, Resident 6 and 73's Location of Administration Record dated 4/2025 were reviewed. LVN 3 reviewed on several days both residents received their insulin injections in the same sites on multiples days hours from the last injection. LVN 3 stated that the nurses should be rotating injections sites each time an injection was given. LVN 3 stated the policy indicated the nurses should be rotating sites. LVN 3 did not confirm that the policy indicated injection sites could be administered per the resident's preference. LVN 3 stated the risk these residents could be discoloration and hardened areas. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 12:25 PM, the Director of Nursing (DON) stated the nurses should be rotating injection sites each time an injection was given. The DON stated she was unsure if the policy indicated that the injection sites could be administered per resident preference. During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, dated 8/30/24, the P&P indicated that injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43851 Based on interview and record review, the facility failed to clarify the physician's orders for hydrocortisone cream (a topical steroid cream applied to the skin to reduce inflammation, redness, itching and swelling) as recommended by the facility's consultant pharmacist (a healthcare professional, who provides specialized expertise to healthcare facilities, typically focusing on ensuring the safe and effective use of medications) during the Monthly Medication Regimen Review (MRR, when a consultant pharmacist reviews and analyzes a resident's medication list, ensuring that the medications are appropriate, effective, and safe) dated 1/13/2025, for one of three sampled residents (Resident 49) reviewed for Unnecessary Medications and Medication Regimen Review. This deficient practice had the potential for Resident 49 to experience adverse effects (undesired and harmful effects that occur because of a medication, treatment, or procedure) from hydrocortisone cream such as skin thinning, skin irritation and/or skin infection. Findings: During a review of Resident 49's Admission Record, the Admission Record indicated the facility readmitted the resident on 9/12/2024 with diagnoses that included Type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), rash (an abnormal skin condition, often characterized by redness, irritation, bumpy, or itchy skin), schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality). During a review of Resident 49's physician's order dated 9/12/2024, the order indicated the resident was to receive 1 % hydrocortisone cream to the right side of his nose and face every 6 hours as needed for itching. The physician's order for 1% hydrocortisone cream had no end date and could be used indefinitely (for an unlimited or unspecified period of time). During a review of the facility's document titled, Consultant Pharmacist's Medication Regimen Review, dated 1/13/2025, the document indicated Resident 49 had an order for hydrocortisone cream without a stop date. The MRR indicated a recommendation to use a topical steroid for no more than four weeks at a time. The MRR indicated for facility staff to ask Resident 49's physician to include a stop date in the order of or discontinue the resident's hydrocortisone cream. During a review of Resident 49's Minimum Data Set (MDS, a resident assessment tool) dated 4/7/2025, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS further indicated Resident 49 was applying ointment/medications to areas other than the feet for skin treatments. (continued on next page)

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	055870	A. Building B. Wing	04/24/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/23/2025 at 2:20 PM, Resident 49's physician's order for hydrocortisone cream dated 9/12/2024 and the facility's document titled Consultant Pharmacist's Medication Regimen Review, dated 1/13/2025 were reviewed with Licensed Vocational Nurse (LVN) 5. LVN 5 verified and confirmed the consultant pharmacist recommended to put a stop date or discontinue Resident 49's physician order for hydrocortisone cream. LVN 5 stated Resident 49's current physician's order for hydrocortisone was indefinite and had no stop date. LVN 5 stated when the consultant pharmacist made a recommendation, the resident's physician had to be notified of the recommendation. LVN 5 stated Resident 49's physician's order should have been clarified with the resident's physician as recommended by the consultant pharmacist. LVN 5 stated consultant pharmacist recommendations had to be followed to help prevent the resident from having unwanted side effects. During a concurrent interview and record review on 4/24/2025 at 9:02 AM, Resident 49's physician's order for hydrocortisone cream dated 9/12/2024 and the facility's document titled Consultant Pharmacist's Medication Regimen Review, dated 1/13/2025 were reviewed with the Director of Nursing (DON). The DON verified the facility's pharmacy consultant recommended to put a stop date or discontinue Resident 49's physician's order for hydrocortisone cream on 1/13/2025. The DON stated Resident 49's current physician's order for hydrocortisone cream did not have a stop date. The DON did not know why Resident 49's physician's order for hydrocortisone cream was not discontinued or clarified. The DON stated that when the pharmacist recommended changes to the residents' medication, the recommendations had to be followed through because medications had adverse effects. The DON stated there could have been a potential for Resident 80 to experience adverse effects of the medication if the pharmacist recommendations were not followed. The DON stated following the pharmacist recommendations could help prevent the resident from experiencing adverse effects of medications. During a review of the facility's policy and procedure titled, IIIA1: Medication Regimen Review (Monthly Report), reviewed 8/30/2024, the P&P indicated The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Resident-specific irregularities and/or clinical significant risks resulting from or associated with medications are documented and reported to the DON, and/or prescriber as appropriate. Recommendations are acted upon and documented by the facility staff and or the prescriber .Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit.

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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** 31333 Based on observation, interview, and record review, the facility failed to ensure the facility's medication error rate (observed or identified preparation or administration of medications or biologicals which was not in accordance with the physician's order, manufacturer's specifications for the preparation and administration of the medication or biological, and professional standards of practice) was not five percent (5%) or greater. There were seven medication errors out of 28 opportunities (observations during medication administration) for error, to yield a cumulative error rate of 25 % for one of four sampled residents (Resident 80) observed during the medication administration. These deficient practices had the potential to result in harm to Resident 80 by not meeting the residents' individual medication and therapeutic needs (the specific types of treatments or interventions that are necessary to address a person's medical condition or improve their overall well-being). Findings: During a review of Resident 80's Admission Record, the admission record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses that included hypertension (HTN, high blood pressure), dependence on respiratory (ventilator, relies on a machine to breathe and cannot breathe independently) status, and gastrotomy tube (G-tube, a surgically placed tube that provides direct access to the stomach for feeding, hydration, or medication administration). During a review of Resident 80's Minimum Data Set (MDS - a resident assessment tool) dated 3/27/2025, the MDS indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated the resident required between moderate to totally dependent on staff for activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 80's April 2025 Physician's Order Summary Report, the report included the following physician's orders: -Amlodipine (use to treat hypertension [HTN], high blood pressure), Oral Tablet 5 mg, dated 12/23/2024, administer one tablet via G-Tube once per day (9 AM) for HTN. Hold for Systolic Blood Pressure (SBP, when the heart contracts and pumps blood) less than 110 millimeters of mercury (mmHg) or Heart Rate (HR) - the number of times the heart beats per minute [bpm]) less than 60 bpm. -Vitamin D3 Oral Capsule 125 mcg (5000 IU), dated 1/21/2025, give one capsule via G-Tube once a day (9 AM) for Vitamin D deficiency. -Ferrous Sulfate (helps red blood cells carry oxygen to tissues and organs) Oral Solution 220 mg/5 ml, dated 4/4/2025, give 7.5 ml via G-Tube once a day (9 AM) for Anemia Give 7.5 ml=330 mg. Shake bottle well. -Folic Acid (helps prevent anemia, low red blood cells), Oral Tablet 1 mg, dated 12/23/2024, give one tablet via G-Tube once a day (9 AM) for Supplement. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Senokot (Sennosides, used to treat constipation) Oral Tablet 8.6 mg, dated 12/23/2024, give two tablets (17. 2 mg) via G-Tube every 12 hours (9 AM and 9 PM) for Bowel Management. Hold for loose stool. -Vitamin B12 Oral Tablet (Cyanocobalamin), dated 4/4/2025, give 1000 mcg via G-Tube once a day (9 AM) for Vitamin B12 deficiency. -Vitamin C Oral Liquid 500 mg /5 ml (Ascorbic Acid), dated 3/26/2025, give 5 ml via G-Tube once a day (9 AM) for Supplement. -Cranberry Oral Tablet 450 MG, dated 1/21/2025, give one tablet via G-Tube once a day (9 AM) for UTI, prophylactically (to prevent). During an observation of medication administration for Resident 80 on 4/21/2025, between 11:33 AM to 12:14 PM, Licensed Vocational Nurse (LVN) 2 was observed preparing the above medications for the 9 AM scheduled medication administration via G-tube. During an interview on 4/21/2025, at 11:33 AM, LVN 2 stated the medications prepared for Resident 80 were to be administered at 9 AM and should have been given to Resident 80 by 10 AM. LVN 2 confirmed a total of eight morning medications were prepared for the resident. During an observation in Resident 80's room on 4/21/2025 at 12 PM, Resident 80 was observed awake, alert, and responded to LVN 2 by nodding his head. LVN 2 administered each medication via the residents' G-tube one by one, flushing with water before and in between each medication, and after completion of the medication administration. LVN 2 was not observed checking the resident's blood pressure or heart rate prior to administering the blood pressure medication, Amlodipine. During an interview on 4/21/2025 at 12:20 PM, LVN 2 stated, I have not notified my supervisor that I was running behind, and I have not called or informed the doctor yet. LVN 2 stated the Registered Nurse Practitioner (NP 1) was at the facility and had not been notified yet. During a concurrent interview and record review, on 4/21/2025 at 12:33 PM with NP 1, Resident 80's blood pressure (BP), heart rate, nursing progress notes, and medication administration records were reviewed for 4/21/2025. Resident 80's BP was documented at 8:04 AM on 4/21/2025 as 138 mmHg/80 mmHg (systolic pressure, top number measures the pressure in the arteries when the heart beats; diastolic pressure, bottom number measures the pressure in the arteries between heartbeats. Normal blood pressure is below 120/80 mmHg). NP 1 stated the licensed nurse (LVN 2) should have checked Resident 80's BP before administering the BP medication, Amlodipine, because the licensed nurse needed to know the resident's BP and HR before giving the BP medications. NP 1 stated the licensed nurse (LVN 2) should not give BP medication based on BP or HR taken hours earlier as the vital signs (reflect essential body functions, including the heartbeat, breathing rate, temperature, and blood pressure) might not have been accurate. NP 1 stated administering Resident 80's Amlodipine too close to the next scheduled BP medication, Metoprolol, scheduled for administration at 2 PM, could cause a drop in the resident HR and cause bradycardia (a heart rate that is slower than normal, generally defined as less than 60 beats per minute (bpm) for adults). NP 1 stated that was the reason the medications (Amlodipine and Metoprolol) were scheduled at different times. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/21/2025 at 12:39 PM, LVN 2 stated she checked Resident 80's BP at 8:04 AM on 4/21/2025 at the start of her shift but had not checked Resident 80's BP before administering the resident's BP medication, Amlodipine at 12:19 PM (four hours later) on 4/21/2025. During an interview on 4/21/2025 at 12:39 PM, Registered Nurse (RN) 1 stated LVN 2 should have informed her that LVN 2 was running late during medication pass before passing the 9 AM medications to Resident 80. RN 1 stated Resident 80's physician had to be informed to make sure there were no contraindications with other medications and to allow the physician to adjust medication administration as needed. During an interview on 4/21/2025 at 3:56 PM, the Director of Nursing (DON) stated Resident 80's BP should have been taken prior to administering BP medications with a parameter (fixed high and low limits in which blood pressure must be to safely administer the medication) to determine when to give or hold a BP medication. The DON stated the facility's policy was to give residents their medications within one hour before or after the scheduled administration time and the nurses had to inform the NP or physician if medications could not be administered on time. During a concurrent interview and record review on 4/21/2025 at 3:56 PM, with the DON, Resident 80's April 2025 Physician's Orders were reviewed and indicated: Metoprolol Tartrate 50 mg, give one tablet via G-tube every eight hours (6 AM, 2 PM, and 10 PM) for HTN. Hold for SBP less than 110 mm Hg or HR less than 60 bpm, order dated 12/23/2024. The DON stated if another medication was due soon after the late medication was administered there could be an overlap of BP medications and the effect of the combined BP medications could have a greater effect on the residents that could lead to confusion, lethargy (sleepiness), or a stroke (occurs when blood flow to the brain is interrupted). The DON stated if medications were not given as scheduled, the physician had to be notified. During an interview on 4/23/2025, at 2:41 PM with the facility's Medical Director (MDR), the MDR stated the physician should have been informed if Resident 80 was going to receive medications later than scheduled. The MDR stated the reason for checking the resident's BP before giving the BP medication was to ensure the licensed nurse followed the parameters that were listed on the physician's order. During a review of the facility's policy and procedure titled, Administering Medications, revision date 4/2019 indicated medications were administered in a safe and timely manner, and as prescribed. Staffing schedules were arranged to ensure that medications were administered without unnecessary interruptions. Medications were administered in accordance with prescriber orders, including any required time frame. Medications were administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The following information was checked/verified for each resident prior to administering medications, vital signs if necessary.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview, and record review, the facility failed to ensure staff followed the Reduced Concentrated Sweets (RCS) diet for blood sugar control, according to the facility's food portioning and serving guide spreadsheet instructions. By failing to ensure residents on RCS diets did not receive garlic bread for lunch on 4/21/2025. This deficient practice could result in increased blood sugar levels for 13 of 64 residents who were on RCS diet. Findings: A review of the facility lunch menu for regular and RCS diets on 4/21/2025 indicated the following items were to be served: Regular diet: Spaghetti with meat sauce 1 cup, tossed salad with dressing 1 cup, garlic bread 1 each, Strawberry poke cake 1 square, and water. RCS diet: Spaghetti with meat sauce 1 cup, tossed salad with dressing 1 cup, strawberry poke cake 1/2 square, and water. During an observation of the tray line service for lunch (a system of food preparation, in which trays move along an assembly line) on 4/21/2025 at 11:45 AM, both regular and RCS diets were observed receiving garlic bread. During a review of the facility's lunch meal food portioning and serving guide spreadsheet, the spreadsheet indicated RCS diet was not to receive garlic bread. During a concurrent observation and interview with Dietary Aide (DA) 2 on 4/21/2025 at 12:30 PM, DA 2 stated his job was to look at the diets and serve the side dishes such as salad, dessert and bread that went on each resident tray along with the main meal. DA 2 confirmed by stating he added the bread and salad to the trays. DA 2 stated regular diets received one square of strawberry poke cake and the RCS diet received 1/2 square of strawberry poke cake. During a concurrent review of the spreadsheet and interview with DA 2 on 4/21/2025 at 12:35 PM, DA 2 stated residents on RCS diet should not have received garlic bread and confirmed the residents were served garlic bread. DA 2 stated serving garlic bread could affect blood sugar levels. During an interview with the Dietary Supervisor (DS) and Registered Dietitian (RD) on 4/21/2025 at 1 PM, the DS stated garlic bread should not have been served on the RCS diet. The DS stated portions and serving directions indicated on the spreadsheet had to be followed. The RD stated staff were to follow diet spreadsheets to make sure residents received the correct nutrition per diet orders. A review of facility policy titled, Controlled-Carbohydrate Diet, revised 2/2025 indicated Controlled Carbohydrate Diet (CC) was used to achieve and maintain sugar control alone or in conjunction with medication. This diet may be appropriate for residents with diabetes or impaired glucose tolerance. In this diet, priority was given to the total amount of carbohydrates consumed at each meal and snack rather than to the specific source of carbohydrate. Portion sizes on this menu must be followed. Consistent timing of meals and snacks was also important.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen, by failing to ensure resident cups, trays, and dishes were clean prior to removing from the dish machine and storing to air dry. This deficient practice had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 64 out 69 residents who received food from the facility kitchen. Findings: During a concurrent observation and interview in the dish washing area, with Dietary Aide (DA) 1 and Dietary Supervisor (DS) on 4/21/2025 at 9:30 AM, DA 1 was observed removing resident trays, cups and bowls from the dishwashing machine and storing them away to air dry. Food particles were observed stuck on trays and plastic cereal bowls. DA 1 was observed removing dishes from the dish machine with visible solid waste on it and returning them to the dishwasher (DW) to be washed again. Trays and bowls were observed washed and stacked to air dry. Food residue was observed on the trays and bowls. Tape was also observed stuck on trays that were stacked away to air dry. During the same observation of the dishwashing area, there were food particles, including small white grains covering the counter where the clean dishes were removed from the dishwashing machine. During a concurrent observation and interview with DA 1 and DS on 4/21/2025 at 9:40 AM, DA 1 confirmed by stating she removed dishes that were dirty and returned the dirty dishes to be washed. DA 1 stated she did not see the bowls and trays with food stains that were stored away to air dry. DA 1 stated the dirty dishes were contaminated and could cause problems in residents. The DS stated the tape on the trays should have been removed before washing. The DS then returned all the trays and cereal bowls to be rewashed. The DS confirmed by stating the clean counter next to the dishwashing machine was covered with food particles. The DS stated the food particles looked like cereal from the morning breakfast. The DS stated the cereal fell from the dishes that were coming out of the dishwashing machine. During a concurrent interview with the DS and the dishwasher (DW) on 4/21/2025 at 9:45 AM, the DW stated breakfast for 4/21/2025 was grits (a type of creamy hot cereal) and was stuck to the dishes. The DW confirmed the trays and cereal bowls were not clean. The DW stated he should have scraped and rinsed longer before loaded into the dishwasher. The DS then instructed the DW to scrape, rinse, and remove all the visible soil from the dishes and then load them in the dish machine. The DS instructed the DW to remove the tape from the trays and rewash all the trays and cereal bowls. The DS then instructed DA 1 and the DW to clean and sanitize the counters before rewashing the dishes. A review of facility policy titled, Sanitization, revised 11/2022 indicated all utensils, counters, shelves and equipment were kept clean, maintained in good repair and were free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 2022 U.S. Food and Drug Administration Food Code, Code 4-603.12 titled, Precleaning, indicated food debris on equipment and utensils shall be scraped over a waste disposal unit or garbage receptacle. If necessary for effective cleaning, utensils and equipment shall be pre flushed, presoaked, or scrubbed with abrasives.