STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055894	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway by the Sea	2725 E. Broadway Long Beach, CA 90803

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure the Responsible Party (RP 1) for one of five sampled residents (Resident 8) was informed when the dosage and frequency of Resident 8's medication ([Ativan] used to treat anxiety [extreme worry]) was changed. one of five sampled residents (Resident 8) Responsible Party (RP) was notified when Resident 8's medication dosage and frequency was changed. This deficient practice resulted in Resident 8's RP not being aware of or understanding the change in Resident 8's medication regimen and had the potential for unnecessary medication administration and side effects/adverse reactions to the unnecessary medication. Findings: During a review of Resident 8's Admission Record (Face sheet), the Face Sheet indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia with severe agitation, palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), anxiety, mood disorder, and a history of falls. During a review of Resident 8's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/21/2024, the MDS indicated Resident 8's cognitive skills for daily decision making were severely impaired and Resident 8 required a one-person substantial/maximal physical assist to complete her activities of daily living ([ADL]) such as dressing, bathing, hygiene, toileting, bed mobility [turning and repositioning] and transferring from chair/bed to chair. During a review of Resident 8's Physician's Order Summary Report (the Physician's Order Summary Report indicated Resident 8 was prescribed the following medications: 1. On 6/14/2024 - Ativan 0.5 mg every four hours as needed (PRN) for agitation and shortness of breath (SOB) for 14 days. 2. On 7/11/2024 - Ativan 1 mg every four hours for agitation and SOB for 14 days. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/18/2024 at 4:30 p.m., RP 1 stated the hospice nurse informed him of Resident 8's increased agitation during the previous week (date unknown) and (RP 1) gave his consent to increase Resident 8's Ativan to 1 mg every four hours PRN for agitation. RP 1 stated he visited Resident 8 on 7/17/2024 at 2 p.m., and Resident 8 would not wake up, was snoring and had bouts of congestion and coughing. RP 1 stated Resident 8 attempted to wake up and say something to him (RP 1), but immediately went back to sleep. RP 1 stated he asked LVN 1 if there had been any changes in Resident 8's condition or medication and LVN 1 told him there were no changes. RP 1 stated he was worried that Resident 8 was overmedicated. During a telephone interview on 7/19/2024 at 12:01 p.m., HN 1 stated she was the one who informed RP 1 that Resident 8's Ativan dosage and administration time was being changed, and she did not know who was responsible to inform RP 1 to obtain an informed consent for new and/or changes to the psychotropic medications. During an interview on 7/22/2024 at 3:16 p.m., the Assistant Director of Nursing (ADON) stated Resident 8's Hospice Physician should obtain the consents for psychotropic medication from the residents and/or their RP before prescribing the medication and the licensed nurses should verify the order with the physician to ensure the consent was obtained from the resident and/or their RP before psychotropic medication is administered. During an interview and record review on 7/22/24 at 4:43 p.m., the Director of Nursing Services (DNS) stated administering a medication not consented by the resident and their responsible parties could affect the residents' health and well-being. During a review of the facility's Policy and Procedure (P/P) on Psychotropic Medications revised 12/2023, the P/P indicated it is the policy of the facility to ensure upon the change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to initiation of the new medication.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45537 Based on interview and record, the facility failed to ensure an injury of unknown origin was reported to the California Department of Public Health (CDPH) for one of seven sampled residents (Resident 1) when Resident 1 sustained a reddish-purple discoloration to the left arm and right rib flank. This deficient practice resulted in the inability of CDPH to investigate Resident 1's injury of unknown injury in a timely manner and had the potential for facts related to the injury to be forgotten by staff. Findings: During a review of Resident 1's Admission Record (Face sheet), the Face sheet indicated Resident 1 was admitted to the facility with diagnosis including chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems), chronic kidney disease (a ,long term condition where the kidneys do not work well as they should) and anemia (a condition that develops when the blood produces a lower than normal amount of healthy red blood cells). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/12/2024, the MDS indicated Resident 1 was able to make independent decisions that were reasonable and consistent. During a review of Resident 1's Skin Evaluation dated 7/3/2024 at 2:11 p.m., the Skin Evaluation indicated Resident 1 had a 1.5 centimeter ([cm] a metric unit of measurement) to the left upper extremity (arm) and a 5. 0 cm by 6.0 cm discoloration to the right ribcage flank of his body with a complaint of pain of 2 out of 10 (an 11 eleven point scale where pain in rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain), to the right ribcage flank area on palpation. During a review of Resident 1's Nursing Progress Notes dated 7/3/2024 at 5:33 p.m., the Nursing Progress Notes indicated Resident 1 was unaware of how the new discoloration to his left arm and right ribcage area occurred. During a telephone interview on 7/16/2024 at 4:01 p.m., Certified Nursing Assistant 1 (CNA 1) stated on 6/30/2024 Resident 1 was observed to have a pair of scissors and was refusing to surrender them. CNA 1 stated Resident 1 allowed LVN 1 to search his pockets, however, after a few minutes, Resident 1 got mad and tried to push LVN 1 away causing Resident 1's wheelchair to almost lean over but LVN 1 was able to stop Resident 1's wheelchair from leaning over and LVN 1 repositioned Resident 1 in his wheelchair. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/16/2024 at 5:10 p.m., LVN 1 stated on 6/30/2024 during the morning shift, he was called to Resident 1's room by the nursing staff because Resident 1 had scissors in his possession and was refusing to surrender them. LVN 1 stated he asked permission from Resident 1 if he could search his pockets while informing Resident 1 residents were not allowed to have scissors in their possession for safety concerns. LVN 1 stated Resident 1 allowed him to search his pockets but when he was patting Resident 1's right pocket, Resident 1 suddenly got mad and tried to push him away and his wheelchair almost leaned over. LVN 1 stated he was able to prevent Resident 1 from falling and repositioned him in his wheelchair. During a telephone interview on 7/16/2024 at 5:44 p.m., LVN 3 stated on 7/1/2024 during the morning shift, he performed a skin evaluation on Resident 1, who had made an allegation that he was attacked by a nursing staff on 6/30/2024. LVN 3 stated Resident 1 had discoloration on his right hand and right arm. LVN 3 stated on 7/3/2024 during the morning shift he was walking by Resident 1's room and saw Resident 1 had new reddish purplish discoloration on his left arm which prompted him to perform a skin evaluation. LVN 3 stated he observed a new reddish purplish discoloration on Resident 1's right ribcage flank area as well, which was painful to touch. LVN 3 stated Resident 1 told him it might be from the incident over the weekend (6/30/2024); however, Resident 1 was not certain about it. LVN3 stated he immediately reported this observation to the Director of Nursing Services. During an interview on 7/17/2024 at 2:10 p.m., the Director of Nursing Services (DNS) stated Resident 1's skin discoloration on his left arm and right ribcage area was new and Resident 1 did not know where this discoloration came from. The DON stated she did an investigation and found out Resident 1 was on a long term anticoagulant (a medication that prevents or treats blood clots, also called a blood thinner, placing persons at risk for bleeding and bruising) in the past and was on steroid therapy (medications used to reduce inflammation and ease swelling, pain, and stiffness) as well as other co-morbidities (two or more disease present at once) which could have caused Resident 1to bruise easily and that was why she did not report this to CDPH. During a review of the facility's undated Policy and Procedure (P/P) titled, Unusual Occurrence Reporting, the P/P indicated an unusual occurrence is any occurrence that constitute an interference with the facility operations that affect the welfare, safety or health of the residents, personnel and visitors and the facility shall report and provide an incident report to the local health officer or the Department of Health in a timely manner. During a review of the facility's P/P, titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised 12/2023, the P/P indicated an alleged violation such as a situation including injuries of unknown source must be reported to the appropriate agencies as designated by State and Federal Laws.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45537 Based on interview and record, the facility failed to conduct a investigation for one of five sampled residents (Resident 1) when Resident 1 reported he was attacked by nursing staff and when reddish-purple discoloration was found on Resident 1's the left arm and the right rib flank area. This deficient practice resulted in the inability of the facility to determine what might have been the cause of Resident 1's injury and had the potential to recur. Findings: During a review of Resident 1's Admission Record (Face sheet), the Face sheet indicated Resident 1 was admitted to the facility with diagnosis including chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems), chronic kidney disease (a ,long term condition where the kidneys do not work well as they should) and anemia (a condition that develops when the blood produces a lower than normal amount of healthy red blood cells). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/12/2024, the MDS indicated Resident 1 was able to make independent decisions that were reasonable and consistent. During a review of Resident 1's Skin Evaluation dated 7/3/2024 at 2:11 p.m., the Skin Evaluation indicated Resident 1 had a 1.5 centimeter ([cm] a metric unit of measurement) to the left upper extremity (arm) and a 5. 0 cm by 6.0 cm discoloration to the right ribcage flank of his body with a complaint of pain of 2 out of 10 (an 11 eleven point scale where pain in rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain), to the right ribcage flank area on palpation. During a review of Resident 1's Nursing Progress Notes dated 7/3/2024 at 5:33 p.m., the Nursing Progress Notes indicated Resident 1 was unaware of how the new discoloration to his left arm and right ribcage area occurred. During a telephone interview on 7/16/2024 at 4:01 p.m., Certified Nursing Assistant 1 (CNA 1) stated on 6/30/2024 Resident 1 was observed to have a pair of scissors and was refusing to surrender them. CNA 1 stated Resident 1 allowed LVN 1 to search his pockets, however, after a few minutes, Resident 1 got mad and tried to push LVN 1 away causing Resident 1's wheelchair to almost lean over but LVN 1 was able to stop Resident 1's wheelchair from leaning over and LVN 1 repositioned Resident 1 in his wheelchair. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/16/2024 at 5:10 p.m., LVN 1 stated on 6/30/2024 during the morning shift, he was called to Resident 1's room by the nursing staff because Resident 1 had scissors in his possession and was refusing to surrender them. LVN 1 stated he asked permission from Resident 1 if he could search his pockets while informing Resident 1 residents were not allowed to have scissors in their possession for safety concerns. LVN 1 stated Resident 1 allowed him to search his pockets but when he was patting Resident 1's right pocket, Resident 1 suddenly got mad and tried to push him away and his wheelchair almost leaned over. LVN 1 stated he was able to prevent Resident 1 from falling and repositioned him in his wheelchair. During a telephone interview on 7/16/2024 at 5:44 p.m., LVN 3 stated on 7/1/2024 during the morning shift, he performed a skin evaluation on Resident 1, who had made an allegation that he was attacked by a nursing staff on 6/30/2024. LVN 3 stated Resident 1 had discoloration on his right hand and right arm. LVN 3 stated on 7/3/2024 during the morning shift he was walking by Resident 1's room and saw Resident 1 had new reddish purplish discoloration on his left arm which prompted him to perform a skin evaluation. LVN 3 stated he observed a new reddish purplish discoloration on Resident 1's right ribcage flank area as well, which was painful to touch. LVN 3 stated Resident 1 told him it might be from the incident over the weekend (6/30/2024); however, Resident 1 was not certain about it. LVN 3 stated he immediately reported this observation to the Director of Nursing Services (DNS). During an interview on 7/17/2024 at 2:10 p.m., the DNS stated Resident 1's skin discoloration on his left arm and right ribcage area was new and Resident 1 did not know where this discoloration came from. The DNS stated she did an investigation and found out Resident 1 was on a long term anticoagulant (a medication that prevents or treats blood clots, also called a blood thinner, placing persons at risk for bleeding and bruising) in the past and was on steroid therapy (medications used to reduce inflammation and ease swelling, pain, and stiffness) as well as other co-morbidities (two or more disease present at once) which could have caused Resident 1 to bruise easily. A review of Resident 1's Clinical Record indicated there was no investigation of Resident 1's allegation of abuse or the bruising to Resident 1's left arm and right rib flank. During a review of the facility's Policy and Procedure (P/P), titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised 12/2023, the P/P indicated an alleged violation such as a situation including injuries of unknown source must be reported to the appropriate agencies as designated by State and Federal Laws and the facility designated staff (management) must conduct a prompt, thorough and complete investigation.

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure one of five sampled residents (Resident 8) did not receive unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior and used to treat mental health disorders). The facility failed to: 1. Ensure Resident 8 w, not prescribed and administered Ativan (a prescription medicine often used to treat people living with anxiety [extreme worry]) 1 milligrams ([mg] a unit of weight measurement), every four hours as needed (PRN) for agitation (feelings of irritability, mental distress, or severe restlessness) and shortness of breath (SOB) for 14 day, without documented indication for use. 2. Ensure Resident 8 was not administered Ativan 1 mg every four hours for six days along with other psychotropic medications (Seroquel and Risperdal), causing Resident 8 to be over sedated. 3. Ensure Resident 8 was not prescribed and administered two antipsychotic (medication used to treat certain mental/mood disorders such as schizophrenia [a mental disorder characterized by abnormal thought processes and deregulated emotions], and bipolar disorder [a mental illness characterized by periods of elevated mood and periods of depression], medications simultaneously, Seroquel 50 mg for dementia (a progressive loss of memory) with psychotic (a person affected with psychosis [a severe mental disorder that causes a person to lose touch with reality and have disrupted thoughts and perceptions] features, manifested by visual hallucinations (false perceptions of things that seem real but are not) of seeing non-existent dead people, ordered on 6/14/2024 and Risperidone 1 mg for a mood disorder manifested by agitation, ordered on 6/20/2024. 4. Ensure Resident 8 was not prescribed antipsychotic medications Seroquel and Risperidone, that were not indicated for use for residents who displayed behaviors related to diagnoses of vascular dementia (a chronic condition that affects memory, thinking and behavior, caused by conditions that damage blood vessels and disrupts blood flow and oxygen supply to the brain) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks). 5. Ensure Resident 8 was not prescribed Ativan 1 mg every four hours as needed for agitation, and Risperdal 1 mg two times daily for a mood disorder manifested by agitation as chemical restraints, as evidenced by interview that Resident 8 often tried to get out of bed unassisted, was at risk of falling and that was why she was given Ativan. 6. Ensure Resident 8 did not receive multiple psychotropic medications (Seroquel, Risperdal and Ativan) simultaneously causing the resident to fall four times from 6/15/2024 thru 7/13/2024. 7. Ensure the licensed nurses notified Resident 8's attending physician when Resident 8 had a change of condition (COC) and Risperdal was held due to drowsiness. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. Ensure Resident 8's medication regimen, including monitoring and assessment of side effects/adverse reactions to psychotropic medications administered to Resident 8, was coordinated with the facility's nursing/medical staff and the Hospice team caring for Resident 8. 9. Ensure Resident 8's Responsible Party 1 (RP 1) was provided an informed consent by the Prescriber of Ativan, when Ativan was increased from 0.5 mg PRN for agitation, to 1 mg every four hours for agitation, and not by the Hospice case manager or the facility nurses. On 7/22/2024 at 6 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), Assistant Director of Nursing (ADON) and the Director of Staff Development (DSD) due to the facility administering unnecessary anti-psychotic medications to Resident 1, causing her to be over sedated. On 7/24/2024, the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 7/24/2024 at 1:31 p.m., in the presence of the facility's ADM and DON. The facility's IJPR included the following immediate actions: 1. The Interdisciplinary ([IDT] a group of professionals from different disciplines who work together to achieve a common goal using their different perspectives and expertise) and the hospice agency reviewed Resident 8's medication regimen and care on 7/23/2024 at 10:00 a.m. 2. The DON and ADON in-serviced all licensed nursing staff on 7/22/2024 and 7/23/2024. Any licensed nursing staff currently on leave will receive an in-service prior to the start of their next shift. The in-services included the following: a. Recognition and documentation of Resident 8's COC. b. Implement interventions that call for non-pharmacological interventions versus the use of psychotropic medications that are not indicated for use with residents with dementia-related behaviors. c. Recognizing, monitoring, documenting, and reporting any COC's associated with adverse effects of medication administration. d. Recognizing when psychotropic medications are not indicated for use. e. Recognizing possible duplicate medication therapy and to follow up with nursing administration and/or the resident's physician for clarification. f. Who is responsible for the consent of psychotropic medications. Corrective Actions: 1. The IDT (consisting of the DON, Social Services Director (SSD), Director of (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Rehabilitation ([DOR] a person qualified to treat disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather by drugs or surgery, who plans, administers, and directs operation of the rehabilitation programs), Dietary Supervisor, Hospice Medical Director, Hospice DON, and Resident 8's family member (FM 1), reviewed Resident 8's medication regimen and care on 7/23/2024 and the residents medications were adjusted. The Seroquel was discontinued on 7/19/2024. The Ativan was changed to 1 mg two times daily PRN. Resident 8 will be seen and evaluated by the psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) on 7/24/2024. 2. The DON and ADM consulted with the Hospice physician on 7/23/2024 and 7/24/2024. Per the physician, in his clinical opinion (and as documented in his clinical note in the resident's chart), Risperdal is justified for the resident at the current dosage, and he has declined to discontinue or lower the dosage of Risperdal. Physician has documented his rationale in the resident's chart. Identification of other Residents: The DON, ADON, and RN Supervisor (RNS) reviewed residents with antipsychotic medications on 7/23/2024. Eleven additional residents with antipsychotic medications were reviewed and none of the residents were identified to have antipsychotic medications prescribed for Dementia or Alzheimer's Disease. Actions Taken to Prevent Reoccurrence: RN Clinical Resource in-serviced the DON and the ADM on 7/22/2024 regarding: a. Recognition and documentation of Resident 8's COC. b. Implement interventions that call for non-pharmacological interventions versus the use of psychotropic medications that are not indicated for use with residents with dementia-related behaviors. c. Recognizing, monitoring, documenting, and reporting any COC's associated with adverse effects of medication administration. d. Recognizing when psychotropic medications are not indicated for use. e. Recognizing possible duplicate medication therapy and to follow up with nursing administration and/or the resident's physician for clarification. f. Who is responsible for the consent of psychotropic medications. The DON and ADON conducted in-services with all licensed nursing staff on 7/22/2024 and 7/23/2024. Any licensed nursing staff currently on leave will receive an equivalent in-service prior to the start of their next shift. The in-services included the following: a. Recognition and documentation of Resident 8's COC. b. Implement interventions that call for non-pharmacological interventions versus the use of psychotropic medications that are not indicated for use with residents with dementia-related behaviors. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. Recognizing, monitoring, documenting, and reporting any COC's associated with adverse effects of medication administration. d. Recognizing when psychotropic medications are not indicated for use. e. Recognizing possible duplicate medication therapy and to follow up with nursing administration and/or the resident's physician for clarification. f. Who is responsible for the consent of psychotropic medications. The DON or designee will review residents with new orders for antipsychotic medications daily (Monday through Friday) to verify the orders are indicated for the residents' diagnoses and behaviors. Monitoring to Ensure Ongoing Compliance: a. The Medical Records Director (MRD) or designee will conduct a review of new orders daily (Monday through Friday) to ensure the informed consent has been obtained from a physician, orders are present for behavior monitoring, side effect monitoring, nonpharmacological interventions if appropriate, and the resident has a care plan in place. Any concerns will be relayed to the DON for follow up daily (Monday-Friday). The MRD was in serviced by the DON on 7/24/2024 regarding this process. b. The DON will report the progress of the monitoring to the Quality Assurance and Performance Improvement ([QAPI] a management approach whose goal is to create, implement, and maintain a program that focuses on systems of care, outcomes of care quality of life, and resident and staff satisfaction) Committee monthly for 6 months or until substantial compliance has been achieved. Completion Date: 7/24/2024 Findings: During a review of Resident 8's Admission Record (Face sheet), the Face Sheet indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, vascular dementia with severe agitation, palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), anxiety, mood disorder, and a history of falls. During a review of Resident 8's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 6/21/2024, the MDS indicated Resident 8's cognitive skills for daily decision making were severely impaired and Resident 8 required a one-person substantial/maximal physical assist to complete her activities of daily living ([ADL]) such as dressing, bathing, hygiene, toileting, bed mobility [turning and repositioning] and transferring from chair/bed to chair. During a review of Resident 8's Physician's Order Summary Report (the Physician's Order Summary Report indicated Resident 8 was prescribed the following medications: 1. On 6/14/2024 - Seroquel 50 mg at bedtime for dementia with psychotic features manifested by visual hallucinations of seeing nonexistent dead people. 2. On 6/20/2024 - Risperdal 1 mg twice a day for a mood disorder, manifested by agitation. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. On 6/14/2024 - Ativan 0.5 mg every four hours as needed (PRN) for agitation and shortness of breath (SOB) for 14 days. 4. On 7/11/2024 - Ativan 1 mg every four hours for agitation and SOB for 14 days. During a review of Resident 8's untitled Care Plan, dated 6/18/2024, the Care Plan (CP) indicated Resident 8 was on an anti-anxiety medication (Ativan). The Care Plan's goals indicated Resident 8 would be free from adverse reactions related to anti-anxiety medications and would have decreased episodes of anxiety. The Care Plan's intervention indicated to administer the anti-anxiety medication, monitor Resident 8 for side effects including drowsiness, lack of energy, clumsiness, dizziness, confusion/disorientation, monitor and record occurrence of target behaviors of agitation and SOB every shift, and provide Resident 8 with non-pharmacological interventions such as redirection, repositioning, offer snacks, assess pain, provide back rubs, provide a quiet environment to express feelings. During a review of Resident 8's untitled Care Plans dated 6/18/2024, the Care Plans indicated Resident 8 was taking anti-psychotic medications ([Risperidone, Seroquel]. The Care Plan's goals indicated Resident 8 would not have any reactions related to the anti-psychotic medication. The Care Plan's interventions indicated to monitor and document Resident 8's episodes of behavior, identify and document Resident 8's adverse reactions/side effects to the anti-psychotic medications, including drowsiness and provide and document non-pharmacological interventions such as redirection, repositioning, offer snacks, assess pain, provide back rubs and a quiet environment. During a review of Resident 8's Medication Administration Record (MAR) dated 6/2024 and 7/2024, the MAR indicated the following: 1. From 6/14/2024 thru 6/30/2024, 7/1/2024 thru 7/11/2024 and 7/17/2024, Resident 8 was administered Seroquel 50 mg at 9 p.m. The MAR from 6/14/2024 thru 7/17/2024 indicated Resident 8's dementia related psychotic features manifested by hallucinations of seeing non-existent dead people, were documented as zero occurrences, and drowsiness and hypotension documented as N (none) on each shift. (7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 a.m. to 7 a.m. shifts). 2. From 6/21/2024 through 6/30/2024, and from 7/1/2024 through 7/17/2024, Resident 8 was administered Risperidone 1 mg twice a day. The MAR dated from 6/21/2024 through 7/17/2024 indicated Resident 8's agitation related to a mood disorder manifested by agitation was documented as zero episodes and side effects related to the anti-psychotic medication including drowsiness and hypotension were documented as N (none) on each shift. 3. On 6/17/2024 at 4:19 p.m., 6/18/2024 at 8:26 p.m., 6/23/2024 at 2:37 a.m., 6/23/2024 at 9:30 a.m., 7/10/2024 at 5:59 p.m., and 7/11/2024 at 4:06 p.m., Ativan 0.5 mg was administered to Resident 8 every four hours for anxiety manifested by agitation and SOB. The MAR dated from 6/17/2024 through 7/17/2024 indicated zero documented occurrences of Resident 8's episodes of anxiety manifested by agitation and SOB and the side effects related to the anti-anxiety medication, including sedation, drowsiness, ataxia (clumsy movements), dizziness, falls and hypotension were documented as N (none) on each shift. 4. The MAR indicated, per Resident 8's Physician's Order, Resident 8 received Ativan 1 mg every four hours as follows: (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. On 7/12/2024 at 12 a.m., 4 a.m., 8 a.m., and 8 p.m. b. On 7/13/2024 at 12 a.m., 4 p.m., and 8 p.m. c. On 7/14/2024 at 12 a.m., 4 a.m., 8 a.m., 12 p.m., 4 p.m., and 8 p.m. d. On 7/15/2024 at 12 a.m., 4 a.m., 8 a.m., 12 p.m., 4 p.m., and 8 p.m. e. On 7/16/2024 at 12 a.m., j4 a.m., 8 a.m., 12 p.m., and 8 p.m. d. On 7/17/2024 at 12 a.m., 4 a.m., and 8 a.m. During a review of Resident 8's Clinical Record, the Clinical Record indicated Resident 8 had four fall incidents from 6/15/2024 through 7/13/2024 during the period that Resident 8 was administered Seroquel, Risperdal, and Ativan as follows: 1. During a review of Resident 8's COC form dated 6/15/2024 and timed at 7:20 a.m., the COC form indicated Resident 8 had an unwitnessed fall and was found on the floor inside her room, face down with her head facing the door. During a review of Resident 8's Nursing Home to Hospital Transfer form dated 6/15/2024 and timed at 7:53 a.m., the Nursing Home to Hospital Transfer form indicated Resident 8 was transferred to a General Acute Care Hospital (GACH) on 6/15/2024 at 7:20 a.m. During a review of Resident 8's COC form dated 6/15/2024 and timed at 3:39 p.m., the COC form indicated Resident 8 was readmitted to the facility with a diagnosis of adult concussion (a mild traumatic brain injury that affects the brain function caused by an impact to the head or body). 2. During a review of Resident 8's COC form dated 6/16/2024 and timed at 8:17 a.m., the COC form indicated Resident 8 had a witnessed fall incident where she lowered herself down on the floor by the doorway of her room, was confused, unable to understand instructions, and unable to walk unassisted. 3. During a review of Resident 8's COC form dated 6/20/2024 and timed at 12:33 a.m., the COC form indicated Resident 8 had an unwitnessed fall, where she was found sitting on a floor mat beside her bed. 4. During a review of Resident 8's COC form dated 7/13/2023 and timed at 1:20 a.m., the COC form indicated Resident 8 had an unwitnessed fall and was found lying on the floor between her and her roommate's bed. The COC form indicated Resident 8 sustained a lump on the right area of the back of her head, complained of pain rated 9 to10 (on an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) to the back of her head and her right and left iliac (upper portion of the hip), and was more confused and sleepier than usual. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 8's Nursing Home to Hospital Transfer Form dated 7/13/2024 at 3:53 a.m., the Nursing Home to Hospital Transfer Form indicated Resident 8 was transferred to a GACH for evaluation and treatment due to a hematoma (an area of blood that collects blood outside of the blood vessels often caused by an injury or trauma) on the right upper area of the back of her head. During a review of Resident 8's COC form dated 7/18/2024 and timed at 6 p.m., the COC form indicated Resident 8 was drowsy with a blood pressure of 80/50 millimeters of mercury ([mmHg] blood pressure unit of measurement. The reference range for adult blood pressure 120/80 mmHg]), a decreased level of consciousness ([LOC] a person's awareness and understanding of what is happening in their surroundings), was sleepy and lethargic (a state of fatigue and low energy). During a telephone interview on 7/18/2024 at 4:30 p.m., RP 1 stated the hospice nurse informed him of Resident 8's increased agitation during the previous week (date unknown) and (RP 1) gave his consent to increase Resident 8's Ativan to 1 mg every four hours PRN for agitation. RP 1 stated he visited Resident 8 on 7/17/2024 at 2 p.m., and Resident 8 would not wake up, was snoring and had bouts of congestion and coughing. RP 1 stated Resident 8 attempted to wake up and say something to him (RP 1), but immediately went back to sleep. RP 1 stated he asked LVN 1 if there had been any changes in Resident 8's condition or medication and LVN 1 told him there were no changes. RP 1 stated he was worried that Resident 8 was overmedicated. During an observation 7/18/2024 at 6:12 p.m., with Certified Nursing Assistant (CNA 5), Resident 8 was observed in bed asleep with her mouth wide open, snoring and breathing slow and deep. Resident 8 was did not respond to repeated verbal and tactile (touching) stimuli (anything that causes a reaction or response) when CNA 5 called her name, asked her to open her eyes held and squeezed both of Resident 8's hands. During an interview on 7/18/2024 at 6:16 p.m., CNA 5 stated Resident 8 had been tired and was sleeping a lot since last week (date unknown) and it was hard for Resident 8 to open her eyes and stay awake in order to eat and drink. CNA 5 stated Resident 8 had never been drowsy like this before and despite being forgetful and/agitated at times, Resident 8 had always been able to follow directions and attend activities. CNA 5 stated RP 1 visited Resident 8 on 7/17/2024 at approximately 2 p.m., and he (RP 1) was concerned about Resident 8's drowsiness. CNA 5 stated RP 1 spoke to the charge nurse (LVN 1) about his concerns. During an interview on 7/18/2024 at 6:02 p.m., LVN 4 stated earlier that day (7/18/2024) during her rounds she observed Resident 8 was lethargic and decided not to give the resident Risperidone because she (LVN 4) was concerned that Resident 8 would not be able to swallow the medicine properly. During an interview on 7/19/2024 at 8:30 am., LVN 1 stated he called the Hospice Nurse (HN 1) to verify Resident 8's consent and the order for Ativan 1 mg, however, he did not document it in Resident 8's chart. LVN 1 stated he did not call Resident 8's physician nor did he create a COC when Resident 8 was observed drowsy and lethargic on 7/17/2024 because he was waiting on the HN 1 to initiate a COC. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 7/19/2024 at 12:01 p.m., HN 1 stated she visited Resident 8 on 7/17/2024 at 9:30 a.m. and observed that Resident 8 was drowsy and unable to wake up despite shaking her up. HN 1 stated she was not informed that Resident 8 had a COC. HN 1 stated she was the one who informed RP 1 that Resident 8's Ativan dosage and administration time was being changed, and she did not know who was responsible to inform RP 1 to obtain an informed consent for new and/or changes to the psychotropic medications. During an interview on 7/19/2024 at 1:36 p.m., RNS 2 stated the licensed nursing staff should monitor the behavior of Residents who take psychotropic medications and the side effects/adverse reactions related to those medications. RNS 2 stated the Hospice Physician should contact the residents and/or their RP to inform them when psychotropic medications were prescribed and/or there are changes to the prescription. During a telephone interview on 7/19/2024 at 4:56 p.m., Resident 8's Hospice Physician stated he prescribed Ativan 1 mg every four hours to Resident 8 because of increased agitation; however, the facility staff must be diligent and monitor Resident 8's response to the medication and call him for any untoward changes in Resident 8's condition. The Hospice Physician stated Resident 8's agitation should be relieved to make her comfortable but not to the point of lethargy. During a telephone interview on 7/22/2024 at 12:58 p.m., LVN 8 stated she gave Resident 8 Ativan 1 mg as ordered (dates unknown), and stated she (LVN 8) was not sure what to assess Resident 8 for prior to administering the Ativan. During a telephone interview on 7/22/2024 at 2:05 p.m., LVN 7 stated he gave Resident 8 Ativan 1 mg as ordered (dates unknown), and did not assess Resident 8 for any side effects or adverse reactions. LVN 7 stated Resident 8 often tried to get out of bed unassisted and was at risk of falling and that was why she was given Ativan. During a telephone interview on 7/22/2024 at 2:52 p.m., LVN 6 stated Resident 8 was on several psychotropic medications and the hospice nurse would usually obtain the consent for the medications from the resident and/or the RP. LVN 6 stated it was the duty of each licensed nurse to verify the order with the physician and to ensure the medication's dose and or/frequency was not over the limit to prevent complications. During an interview on 7/22/2024 at 3:16 p.m., the Assistant Director of Nursing (ADON) stated Resident 8's Hospice Physician should obtain the consents for psychotropic medication from the residents and/or their RP before prescribing the medication and the licensed nurses should verify the order with the physician to ensure the consent was obtained from the resident and/or their RP before psychotropic medication is administered. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and record review on 7/22/2024 at 4:43 p.m., the DON stated the consent for a psychotropic medication should be obtained by the physician prior to administering the medication. The DON stated monitoring should be conducted and documented to ensure accurate information was collected to determine if a gradual dose reduction ([GDR] tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose can be discontinued) of the Resident 8's psychotropic medications were appropriate and if Resident 8 had any side effects and/or adverse reactions associated with the medications. The DON stated the licensed nurses should inform the physician immediately if there is a COC so there is no delay in evaluation and treatment of the resident. The DON stated the care provided by the facility and the Hospice agency must be collaborative to ensure there is no delay in the delivery of care and services. During a review of the facility's Policy and Procedure (P/P) titled, Psychotropic Medications revised 12/2023, the P/P indicated it is the policy of the facility to: a. Ensure that residents are not given any psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. b. Ensure such medications should not be administered for the purpose of discipline or convenience and will be considered only after nonpharmacological interventions have been attempted and failed. c. Ensure efforts will be made by the licensed nurses to verify informed consents from the resident and their responsible party and must be documented in the resident's clinical record before carrying out the physician's orders. d. Ensure the licensed nurses shall review the classification of the drug, the appropriateness of the diagnosis and its indication, behavior monitored and related adverse side effects prior to verification of the admission and such behavior monitoring and/monitoring of adverse side effects shall be documented in the resident records/or physician orders. e. Ensure upon the change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to initiation of the new medication. During a review of the facility's (P/P) titled, Care and Treatment Psychotropic Drug Use revised 8/2017, the P/P indicated the psychotropic medication was prescribed to treat a specific diagnose condition, as documented in the chart: a. Should not be in excessive dose. b. Monitoring for adverse consequences and effectiveness of medications are in place and documented. c. Informed consent was obtained prior to medication use. (continued on next page)

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F 0758 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of the facility's P/P titled, Significant Change of Condition, Response revised 12/2023, the P/P indicated residents of the facility must receive quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing including during a change of condition. The P/P indicated the licensed nurses must perform and document an assessment of the resident and identify the need for additional interventions, considering implementation of existing orders or nursing interventions or through the resident's provider using the SBAR (Situation Background Assessment Recommendation) to obtain new orders or interventions and the licensed nurse shall use his/her clinical judgement to contact the physician based on the urgency of the situation and the resident's representative will be notified on the change of condition and any changes in the resident's medical or nursing care.