STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055983	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coventry Court Health Center	2040 S. Euclid Avenue Anaheim, CA 92802

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 84) observed during medication pass observation. * Resident 84 was assessed not for safe self-administration of the medications when Resident 84 was observed with a Cepacol Extra-Strength Sore Throat Benzocaine 15 mg/menthol 2.6 mg lozenges (lozenges containing medication to relieve sore throat and pain) at the resident's bedside. In addition, the facility failed to ensure a care plan was developed to address the self-administration of the medications for Resident 84. These failures had the potential for Resident 84 to self-administer the medications inaccurately and negatively affect Resident 84's well-being. Findings: Review of the facility's P&P titled Self-Administration of Medications by Residents (undated) showed the following:- Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team (IDT) has determined that the practice would be safe for the resident and other residents of the facility.- It is the responsibility of the IDT to determine if it is safe for the resident to self-administer drugs before the resident may exercise that right. The IDT must determine whether the resident or the nursing staff will be responsible for storage and documentation of the administration of the medications, as well as the location where the medications will be administered. These determinations should appear on the resident's comprehensive plan of care- All nurses and aides are required to report to the charge nurse on duty any medications found at the beside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. On 7/24/25 at 0827 hours, an observation and concurrent interview was conducted with Resident 84. A plastic bag with medication was observed in the side of the duffle bag on Resident 84's bed. Resident 84 stated the medication was her cough drops she took with her to the dialysis center because her throat gets dry. Medical record review for Resident 84 was initiated on 7/24/25. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's H&P examination dated 11/18/24, showed Resident 84 had the capacity to understand and make decisions. Review of Resident 84's medical record failed to show an assessment was conducted by the IDT of Resident 84's ability to self-administer medications. Review of Resident 84's Order Summary Report dated 7/23/25, failed to show for a physician's order for the Cepacol Extra-Strength Sore Throat Benzocaine 15 mg/menthol 2.6 mg; and to allow Resident 84 to self-administer the medication. Review of Resident 84's Care Plan Report (undated) failed to show a care plan problem was developed to address Resident 84's self-administration of the Cepacol Extra-Strength Sore Throat Benzocaine 15 mg/menthol 2.6 mg medication. On 7/24/25 at 0827 hours, an observation and concurrent interview for Resident 84 was conducted with LVN 7. LVN 7 verified Resident 84 had a package of Cepacol Extra-Strength Sore Throat Benzocaine 15 mg/Menthol 2.6 mg in the duffle bag on her bed. LVN 7 verified Resident 84 would need to have an assessment, physician's order, and care plan to keep the medication at bedside. LVN 7 also verified there was no assessment, physician's order, or care plan for the self-administration of the medications, therefore Resident 84 should not have had the medication at the bedside.

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

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 contained complete information for one of three nonsampled residents (Resident 110) reviewed for beneficiary notices. The SNF ABN Form CMS-10055 is used to inform residents of the potential financial liability and appeal rights and protections should they wish to receive care and services that may not be covered by Medicare. This failure had the potential of not allowing the residents to make an informed decision regarding their Medicare services.Findings: Review of the facility's P&P titled Advanced Beneficiary Notice of Non-Coverage (Part A) revised 3/2018 showed the ABN is used for beneficiaries in original (fee-for service) Medicare when the facility believes that Medicare is not likely to cover the services described in the ABN. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. Closed medical record review for Resident 110 was initiated on 7/24/25. Resident 110 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 110 was discharged from the facility on 2/17/25. Review of Resident 110's SNF ABN Form CMS-10055 dated 1/31/25, failed to show the estimated daily cost of the services for Resident 110. The form showed Resident 110 selected Option 1, to receive the listed services and to bill Medicare. if Medicare did not pay, Resident 110 would be responsible for paying. On 7/24/25 at 1052 hours, an interview and concurrent closed medical record review for Resident 110 was conducted with the SSD. The SSD was asked to explain her role in providing the residents with the SNF ABN forms. The SSSD stated when the residents were exhausting their Medicare skilled services at the facility, the SSD was responsible for providing the residents with the SNF ABN forms prior to the last day of the covered services (paid by Medicare). The SSD stated the SNF ABN form notified the residents of the last covered day, the care and services that were paid for by Medicare, and the estimated cost of the care. The SSSD stated the residents were provided with the options to receive the care and bill Medicare (however, if Medicare did not pay, the resident would be responsible for paying), receive the care and not bill Medicare, or decline the care. The SSD reviewed Resident 110's SNF ABN form and verified the estimated daily amount of services was not disclosed on the notice. The SSD stated there should have been an amount on the notice so Resident 110 would be fully informed of the amount she would be responsible for paying if Medicare did not pay. On 7/24/25 at 1148 hours, a follow-up interview was conducted with the SSD. The SSD stated there was no other documentation in Resident 110's medical record to show Resident 110 was informed of how much she would be responsible for paying if the Medicare did not pay for the services. On 7/29/25 at 1122 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of five final sampled residents (Residents 7, 71, and 109) reviewed for unnecessary medications were free from the unnecessary psychotropic medications. * The facility failed to ensure Resident 109's physician's order and informed consent for the use of the quetiapine (antipsychotic medication) and risperidone (antipsychotic medication) medications included the diagnoses and the specific behavior manifestation; and the psychoactive medication evaluation and care plan were initiated for the use of the quetiapine and risperidone medication. In addition, the facility failed to ensure the physician's order for the use of the PRN alprazolam medication (antianxiety) had a stop date. * The facility failed to ensure Resident 71's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the quetiapine medication. In addition, the facility failed to accurately monitor Resident 71's behavior and implement the non-pharmacological interventions for Resident 71's use of the quetiapine medication. * The facility failed to ensure Resident 7 was not prescribed with two antidepressant medications for the same behavior manifestation. These failures had the potential for the residents to have adverse effects from the psychotropic medications and prescriber to have incorrect data when adjusting the dosage of the psychotropic medications.Findings: Review of the facility's P&P titled Psychotropic Medications revised 2/2024 showed based on a comprehensive assessment, the facility will ensure that: - Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless contraindicated, in an effort to discontinue these drugs; - PRN orders for psychotropic drugs are limited to 14 days. Except for PRN orders for anti-psychotic medications, if the attending physician or prescribing practitioner believes that it is appropriate or the PRN psychotropic medication order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN (as needed) order. Further review of the facility’s P&P showed on admission, the admitting nurses will review the transfer orders for any psychotropic medicators. The licensed nurse shall review the classification of the drug, the appropriateness of the diagnosis, its indication, monitors behavior, and related adverse side effects prior to verification of admission orders with the Attending Physician. The medical record must show documentation of the diagnosed condition for which a psychotropic medication is prescribed. Upon change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to the initiation of the new medication. New physician’s orders for the psychotropic medications will be communicated to the Social Services department for review with the IDT and appropriate care planning will be done to ensure updated information in the resident’s psychosocial care plan. 1. Medical record review for Resident 109 was initiated on 7/22/25. Resident 109 was admitted to the facility on [DATE], with diagnoses of anxiety disorder and vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, and mood disturbance. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 109’s H&P examination dated 7/17/25, showed Resident 109 could make his needs known but could not make medical decisions. Review of Resident 109’s Order Summary Report for July 2025 showed a physician’s order dated 7/17/25, for the following: - to administer quetiapine (antipsychotic medication) 25 mg one tablet daily for hallucinations. - for the use of the quetiapine medication, to monitor Resident 109 for the episodes of psychotic behavior as evidenced by hallucinations, every shift, and - to administer risperidone (antipsychotic medication) 1 mg one tablet every 12 hours for hallucinations. a. Review of Resident 109’s Informed Consent for quetiapine medication dated 7/17/25, showed a consent was obtained for the use of quetiapine 25 mg every day at noon. The facility documented “manifested by hallucinations” for the reason for treatment. Review of Resident 109’s Informed Consent for risperidone medication dated 7/17/25, showed a consent was obtained for the use risperidone 1 mg two times a day. The facility documented “manifested by hallucinations” for the reason for treatment. Further review of Resident 109’s order summary report and informed consents failed to show the diagnosis for the quetiapine and risperidone medications. b. Review of Resident 109’s medical record failed to show a psychoactive medication evaluation was conducted for Resident 109’s use of the quetiapine and risperidone psychotropic medications. Review of Resident 109’s plan of care failed to show a care plan problem was developed to address Resident 109’s hallucinations or the use of the quetiapine and risperidone psychotropic medications. Review of Resident 109’s MAR for July 2025 showed Resident 109 was administered the antipsychotic medications on the following date and times: - quetiapine medication 25 mg daily on 7/17 to 7/22/25 at 1200 hours, - risperidone medication 1 mg every 12 hours on 7/17/25 at 2100 hours, 7/18 to 7/22/25 at 0900 and 2100 hours, and 7/23/25 at 0900 hours. Further review of the MAR for July 2025 showed Resident 109 was monitored for the episodes of psychotic behaviors as evidenced by hallucinations for the use of the quetiapine medication on 7/17/25, during the PM and NOC shift, and from 7/18 to 7/22/25, during the day, PM, and NOC shifts. However, the MAR failed to show the specific type of hallucination Resident 109 was monitored for. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/25 at 1356 hours, an interview and concurrent medical record review for Resident 109 was conducted with the DON. The DON stated the informed consent for the use of the psychotropic medications should include the ordered psychotropic medication, the dose, frequency, diagnosis, and manifested behaviors. The DON stated the informed consent was obtained by the physician and the licensed nurse was responsible for verifying the informed consent was obtained prior to the administration of the psychotropic medication. The DON stated the licensed nurse was responsible for ensuring the information on the informed consent was accurate, and if it was not, the licensed nurse should clarify the information with the physician. The DON stated the psychoactive medication evaluation was initiated upon the resident’s admission to the facility and when a psychotropic medication was prescribed to the resident. The DON verified the psychoactive medication evaluation was not conducted for Resident 109’s use of the quetiapine and risperidone medication. Additionally, the DON stated there was no care plan initiated for Resident 109’s use of the antipsychotic medications or for the symptoms of hallucinations. When asked about Resident 109’s symptoms of hallucinations, the DON stated the behavior was not specific and did not indicate if Resident 109 was having auditory or visual hallucinations. On 7/24/25 at 1536 hours, follow-up interview and concurrent medical record review for Resident 109 was conducted with the DON. The DON stated the licensed nurse who entered the physician’s orders was expected to ensure there was a proper diagnosis for the medication prescribed. The DON stated if the diagnosis was not documented, the licensed nurse should contact the physician and clarify the order. The DON stated the licensed nurse should have clarified the diagnosis and the manifesting behaviors to ensure Resident 109 was properly monitored for the use of the antipsychotic medication. c. Review of Resident 109’s Order Summary Report showed a physician’s order dated 7/15/25, to administer alprazolam (antianxiety medication) 0.25 mg one tablet by mouth every 24 hours as needed for anxiety manifested by verbalization of feeling anxious. However, the physician’s order for PRN alprazolam failed to include a stop date. Review of Resident 109’s MAR for July 2025 showed Resident 109 was administered the alprazolam 0.25 mg medication on 7/23/25 at 0515 hours. On 7/24/25 at 1356 hours, an interview and concurrent medical record review for Resident 109 was conducted with the DON. The DON stated the licensed nurses were responsible for ensuring the physician’s orders for the PRN psychotropic medications had a stop date. The DON further stated if the PRN psychotropic medication order did not have a stop date, the licensed nurses were expected to contact the physician to clarify the order. The DON reviewed Resident 109’s medical record and verified the above findings. 2. Medical record review for Resident 71 was initiated on 7/22/25. Resident 71 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 71’s H&P examination dated 4/2/25, showed Resident 71 had a fluctuating capacity to understand and make decisions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of Resident 71’s Order Summary Report dated 7/2025, showed a physician’s order dated 4/1/25, to obtain Resident 71’s orthostatic BP (blood pressure) in the lying position every seven days, and to wait 15 minutes prior to position changes; and obtain Resident 71’s orthostatic BP in the sitting position every seven days, and to wait 15 minutes prior to position changes. Review of Resident 71’s MAR for June 2025 showed the following: - dated 6/13/25, the BP readings were documented as 119/61 mmHg for both the lying and sitting position, and - dated 6/20/25, the BP readings were documented as 134/76 mmHg for both the lying and sitting position. On 7/28/25 at 1425 hours, an interview and concurrent medical record review for Resident 71 was conducted with LVN 2. LVN 2 stated Resident 71 was monitored for orthostatic hypotension weekly, by obtaining Resident 71’s BP readings in the lying and sitting positions. LVN 2 reviewed Resident 71’s medical record and verified the above findings. LVN 2 stated the BP readings should not be the same. On 7/29/25 at 1100 hours, an interview was conducted with the DON. The DON stated the residents on the psychotropic medications were monitored every shift for side effects related to the use of the psychotropic medication, such as headache, dizziness and orthostatic hypotension. The DON stated the licensed nurse was expected to compare the BP readings and determine if there was a drastic drop in the BP. The DON stated the BP readings should not be the same for the different positions. b. Review of Resident 71’s Order Summary Report for July 2025 showed the following physician’s orders: - dated 4/1/25, for the use of the quetiapine antipsychotic mediation, to monitor Resident 71 for episodes of schizoaffective disorder behavior as evidenced by angry outburst for no apparent reason and provide the nonpharmacological interventions and document the interventions as follows: 0-back rub, 1-redirection, 2-speak to/approach in a calm manner, 3- reposition, 4- offer snacks/fluid/milk, 5- assess for pain, 6- provide a quiet environment, 7- encourage to express feelings, 8- take to activities, 9- provide reassurance, every shift, and - dated 7/1/25, to administer quetiapine 100 mg one tablet by mouth two times a day for schizoaffective disorder manifested by angry outbursts for no apparent reason. Review of Resident 71’s plan of care showed a care plan problem dated 4/3/25, addressing Resident 71’s use of the antipsychotic medication related to the diagnosis of schizophrenia manifested by angry outbursts. The interventions included to document the episodes of Resident 71’s behavior, and to document the nonpharmacological interventions: back rub, speak to/approach in a calm manner, reposition, offer snacks/fluids, assess for pain, provide a quiet environment. Review of Resident 71’s MAR for June and July 2025 showed the number of episodes Resident 71 had for schizoaffective disorder behavior as evidence by angry outburst for no apparent reason on the following dates and shifts: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 6/1/25, during the NOC shift, two episodes; - dated 6/2/25, during the dayshift, two episodes, and during the PM shift, one episode; - dated 6/4/25, during the NOC shift, one episode; - dated 6/12/25, during the NOC shift, one episode; and - dated 7/4/25, during the NOC shift, one episode. Further review of the MAR for June and July 2025 showed the licensed nurses documented the behaviors were observed on the above dates and shifts, however, the licensed nurses documented “NA” for the nonpharmacological interventions implemented related to the use of the quetiapine medication. Additionally, on the days the licensed nurses documented “0” behaviors were observed during the shift, the licensed nurses were documenting the nonpharmacological interventions implemented for the behavior. For example: - dated 6/1/25, for the day shift, showed the licensed nurse documented Resident 71 was provided with 1-redirection, 2-spoke to/approached in a calm manner, and 3- repositioning; however, the licensed nurse documented “0” behavior during the shift. - dated 6/9/25, for the NOC shift, showed the licensed nurse documented Resident 71 was provided with 2-spoke to/approached in a calm manner, 3- repositioning, and 6- provided a quiet environment; however, the licensed nurse documented “0” behavior during the shift. - dated 7/10/25, for the PM shift, showed the licensed nurse documented Resident 71 was provided with 3-repositioning, 6- provided a quiet environment, and 9- provided reassurance; however, the licensed nurse documented “0” behavior during the shift. - dated 7/11/25, for the PM shift, showed the licensed nurse documented Resident 71 was provided with 1-redirection, 2-spoke to/approached in a calm manner, and 3- repositioning; however, the licensed nurse documented “0” behavior during the shift. On 7/24/25 at 1622 hours, an interview and concurrent record review for Resident 71 was conducted with LVN 6. LVN 6 stated the licensed nurses were responsible for monitoring Resident 71 for the episodes of angry outbursts and documenting the observed behaviors every shift. LVN 6 stated if the behavior was observed, the licensed nurse should implement the nonpharmacological interventions and document in the MAR. LVN 6 further stated, if the licensed nurse documented the implementation of the nonpharmacological interventions for the behavior, then there should have been a documentation of the behavior observation during that shift. LVN 6 verified on 7/10 and 7/11/25 during the PM shift, she had documented she provided the nonpharmacological interventions to Resident 71; however, under the monitoring of Resident 71’s behavior, LVN 6 had documented “0. LVN 6 verified the finding and stated her documentation of Resident 71’s behavior was inaccurate. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/25 at 1425 hours, an interview and concurrent medical record review for Resident 71 was conducted with LVN 2. LVN 2 reviewed Resident 71’s MAR for June 2025 and verified the above findings and stated the monitoring of behavior and documentation of the nonpharmacological intervention was inaccurate. LVN 2 stated if a behavior was observed, the nonpharmacological interventions should not be documented as “NA.” On 7/29/25 at 1100 hours, an interview was conducted with the DON. The DON stated for the licensed nurse shall review the classification of the drug, appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician. Upon the initial comprehensive assessment, the SSD designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications. The facility's Interdisciplinary Team (IDT) will review to ensure: the psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record; not in excessive dosage; behavior is not related to delirium or other reversible conditions; and monitoring for adverse consequences and effectiveness of medications are in place. Medical record review for Resident 7 was initiated on 7/22/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7’s H&P examination dated 5/10/25, showed Resident 7 had capacity to understand and make decisions. Review of Resident 7's Order Summary Report dated 7/24/25, showed a physician's order dated 5/8/25, for Remeron oral tablet (an antidepressant medication) 7.5 mg give one tablet by mouth once a day for depression manifested by episodes of verbalization of sadness and bupropion hydrochloride extended-release oral tablet (an antidepressant medication) 150 mg give one tablet by mouth once a day for depression manifested by verbalization of feeling sad. On 7/24/25 at 1530 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 4. LVN 4 verified and acknowledged the Remeron and bupropion medications had the same indication for the antidepressant use and behavior manifestation of verbalization of sadness. LVN 4 further stated the licensed nurse should have clarified with the physician. On 7/24/25 at 1600 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 5. LVN 5 acknowledged the monitoring of the same behavior for Remeron and bupropion medications would make it challenging to determine the effectiveness of the medications. LVN further stated the staff should have clarified the medication orders with the physician. On 7/24/25 at 1620 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON stated the licensed nurse had clarified with the physician that the medication for Remeron should have been indicated for poor oral intake.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to complete the timely discharge MDS assessments for two of two nonsampled residents (Residents 6 and 76) investigated for resident assessments. This failure resulted in a delay of submitting the data to CMS regarding the residents' health and functional status at the time of their discharge from the facility. Findings: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1 showed Discharge Assessments must be completed by 14 days after the discharge date . 1. Closed medical record review for Resident 76 was initiated on 7/23/25. Resident 76 was admitted to the facility on [DATE], and discharged on 2/26/25. Review of Resident 76's Discharge MDS assessment dated [DATE], showed the MDS assessment was signed as completed on 7/16/25 (more than four months after the required completion date of 3/14/25). On 7/24/25 at 0805 hours, an interview and concurrent closed record review was conducted with the MDS Assistant. The MDS Assistant stated the discharge MDS assessments must be completed by the 14 days after the resident's discharge. The MDS Assistant reviewed Resident 76's Discharge MDS assessment dated [DATE], and verified it was not completed on time. 2. Closed medical record review for Resident 6 was initiated on 7/23/25. Resident 6 was admitted to the facility on [DATE], and discharged on 6/19/25. Review of the Resident 6's Discharge MDS assessment dated [DATE], showed the MDS assessment was signed as completed on 7/21/25 (18 days after the required completion date of 7/3/25). On 7/24/25 at 0810 hours, an interview and concurrent record review was conducted with the MDS Assistant. The MDS Assistant reviewed Resident 6's Discharge MDS assessment dated [DATE], and verified it was not completed on time.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of four sampled residents (Residents 10 and 71) reviewed for PASRR were accurately screened. * The facility failed to ensure Level II PASRR screenings were completed following a positive Level I PASRR screening. This failure posed the risk for Residents 10 and 71 being not properly screened, and the risk of not receiving adequate level of services, comprehensive assessment, and intervention. Findings: According to https://www.dhcs.ca.gov/services/MH/Pages/PASRR_faq_level2.aspx: - PASRR consists of a Level 1 Screening, a Level 2 Evaluation (if needed), and a Determination. If the Level 1 Screening is positive, a PASRR Level 2 Evaluation will be performed. A Level 2 Evaluation is a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, i.e., serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC). The Level 2 Evaluation helps determine the most appropriate placement of an individual, considering the least restrictive setting, and whether specialized services are needed. - The Level 2 Evaluation has three main goals: o Confirm whether the individual has an SMI or ID/DD or RC; o Assess the individual’s need for Medicaid certified nursing facility (NF) services; and o Assess whether the individual requires specialized services. According to the DHCS, federal law requires all individuals seeking admission to a Medicaid Certified Nursing Facility (NF) to receive a Level 1 Screening. The Level 1 Screening identifies if an individual has a suspected Mental Illness (MI) or an Intellectual/Developmental Disability or Related condition (ID/DD/RC). If MI is suspected, then a Level II Mental Health Evaluation may be conducted to determine if the individual can benefit from specialized mental health services. This process is known as the Preadmission Screening and Resident Review (PASRR). Review of the facility’s P&P titled PASRR revised 7/2022 showed the following: - It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. Upon admission of a resident to the facility, the Admissions or Licensed Nursing personnel will complete the Level 1 PASRR. - A PASRR shall be completed on every resident upon admission. - After admission, IDT members will review the assessment for accuracy and the need for PASRR Level II referral. Based upon the assessment, the facility will ensure the proper referral to the appropriate state agencies for the provision of specialized services to residents with Intellectual Disability/Related Condition or Serious Mental Illness. (continued on next page)

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	055983	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coventry Court Health Center	2040 S. Euclid Avenue Anaheim, CA 92802

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Medical record review for Resident 10 was initiated on 7/28/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10’s PASRR Level 1 Screening Results dated 11/21/24, showed a SMI Level II Mental Health Evaluation was required and an ID/DD/RC Level II Mental Health Evaluation was not required. Further review of Resident 10’s medical record failed to show documented evidence of a follow-up call or inquiry being sent to DHCS, or the submission of a new Level I PASRR screening. On 7/28/25 at 1352 hours, an interview and concurrent medical record review for Resident 10 was conducted with the MDS Assistant. The MDS Assistant verified Resident 10’s Level I PASRR screening was completed; however, RN 1 was unable to locate documentation of a follow-up attempted by the facility to address the need for Level II Mental Health Evaluation, or the submission of a new Level I PASRR screening for Resident 10. 2. Medical record review for Resident 71 was initiated on 7/22/25. Resident 71 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 71’s H&P examination dated 4/2/25, showed Resident 71 had fluctuating capacity to understand and make decisions. Review of Resident 71’s PASRR Level I Screening dated 4/7/25, showed Resident 71 had a positive Level I Screening for serious mental illness. Review of Resident 71’s Notice of PASRR Level I Screening Results dated 4/7/25, showed a serious mental illness Level II Mental Health Evaluation was required. Further review of Resident 71’s medical record failed to show a new Level I Screening was submitted. On 7/23/25 at 1503 hours, an interview and concurrent medical record review for Resident 71 was conducted with the MDS Nurse. The MDS Nurse stated when the Level I Screening was positive, a Level II Evaluation would be needed, and a follow-up would be required. The MDS Nurse stated the State agency usually contacted the facility to follow-up on the Level II Evaluation within a few days of the positive Level I Screening. The MDS Nurse stated if the facility had not heard from the State agency in 72 hours, the facility would follow-up with DHCS. The MDS Nurse reviewed Resident 71’s medical record and verified the above findings. The MDS Nurse stated if the State agency was unable to contact the facility to conduct the Level II Evaluation, the facility should complete another Level I PASRR Screening to ensure another Level II Evaluation would be done. On 7/23/25 at 1601 hours, a follow-up interview was conducted with the MDS Nurse. The MDS Nurse stated a PASRR Level I Screening was not completed and should have been completed for Resident 71 after the facility had received the notification from DHCS. On 7/29/25 at 1122 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop a plan of care to reflect the individual care needs for two of 19 final sampled residents (Residents 1 and 24). * The facility failed to develop a care plan to address Resident 1's refusal of the COVID-19 vaccine. * The facility failed to develop a care plan to address Resident 24's noncompliance with the continuous use of oxygen via nasal cannula as ordered by the physician. These failures posed the risk of the residents not receiving the appropriate treatment and services.Findings: Review of the facility’s P&P titled Care Plan and Care Plan Update revised 2/2022 showed it is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The Procedures section showed the care plan will be initiated based on identified problem and medical change of condition. 1. Medical record review for Resident 1 was initiated on 7/22/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1’s H&P examination dated 5/1/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1’s immunization report dated 2/1/24 through 7/31/25, showed Resident 1 had refused to receive the COVID-19 vaccination. Review of Resident 1’s medical record failed to show a care plan problem was initiated to address the resident’s refusal to receive the COVID 19 vaccination. On 7/25/25 at 1438 hours, an interview was conducted with the IP. The IP stated when a resident refused a vaccination, the IP would initiate a care plan for those who refused. On 7/29/25 at 1531 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 1. RN 1 stated if a resident refused a vaccination, there should be a care plan initiated. RN 1 reviewed Resident 1’s plan of care and verified there was no care plan initiated for the refusal of COVID-19. On 7/29/25 at 1608 hours, the Administrator, DON, and Clinical Resource were informed and acknowledged the findings. 2. Medical record review for Resident 24 was initiated on 7/22/25. Resident 24 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 24’s H&P examination dated 7/8/25, showed the resident had the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 24’s Order Summary Report dated 7/24/25, showed a physician’s order dated 7/14/25, for continuous oxygen at 2 LPM via nasal cannula/mask to keep oxygen saturation above 90% every shift related to COPD. Further review of Resident 24’s medical record failed to show documented evidence of the care plan for the resident's noncompliance with the continuous use of oxygen via nasal cannula. On 7/24/25 at 0756 hours, an observation and concurrent interview was conducted with Resident 24. Resident 24 was observed without oxygen via nasal cannula. Resident 24’s nasal cannula was observed inside a plastic set up bag. The oxygen was on 2 LPM and the nasal cannula was connected to the oxygen concentrator. Resident 24 stated a staff was with him when he removed his nasal cannula. On 7/24/25 at 1031 hours, an observation and concurrent interview for Resident 24 was conducted with CNA 4. CNA 4 stated Resident 24 sometimes removed his oxygen, and the resident put it back on. CNA 4 stated he asked Resident 24 to put back the oxygen if he saw him without the oxygen. CNA 4 stated he saw Resident 24 removed his oxygen a few times, however, he could not recall when he last saw Resident 24 without the oxygen. On 7/24/25 at 1131 hours, an interview and concurrent medical record review for Resident 24 was conducted with LVN 4. LVN 4 verified there was no care plan for Resident 24’s noncompliance with the continuous use of oxygen via nasal cannula. LVN 4 stated the licensed nurse should have started a care plan for the Resident 24’s noncompliance with the continuous use of the oxygen via nasal cannula. LVN 4 further stated he saw Resident 24 removed the nasal cannula before and he asked the resident to put it back. LVN 4 stated Resident 24 was able to put back his nasal cannula. LVN 4 stated he did not remember the date when Resident 24 removed his nasal cannula. On 7/25/25 at 1357 hours, an interview and concurrent medical record review for Resident 24 was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse who observed Resident 24 being non-compliant should have addressed in the care plan about the resident’s noncompliance with the continuous use of the oxygen via nasal cannula.

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F 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of 19 final sampled residents (Resident 54). * The facility failed to follow-up in scheduling Resident 54's outside urology consultation as ordered by the physician. This failure had the potential to result in Resident 54 not receiving appropriate services, treatment, and care. Findings: Review of the facility's P&P titled Resident Appointment and Transportation revised 5/2007 showed the facility social services and or designee will assist the residents or responsible representatives in scheduling for appointments including but not limited to diagnostic procedures outside the facility. On 7/24/25 at 1131 hours, Resident 54 was observed lying in bed resting with eyes closed. A suprapubic urinary catheter tubing was observed attached to the resident. Medical record review for Resident 54 was initiated on 7/28/25. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's Order Summary Report dated 7/29/25, showed a physician's order dated 3/28/25, for suprapubic urinary catheter size #16 Fr/10 ml to closed drainage system. In addition, there was a physician's order dated 7/22/25, for urology consult for suprapubic catheter change. Review of Resident 54's Progress Note dated 7/22/25, showed the Case Manager contacted an outside facility confirming the eligibility of a consultation with a urologist. The outside facility advised the Case Manager to call back if no response was received by 1800 hours on the same day. On 7/29/25 at 1010 hours, an interview was conducted with LVN 4. LVN 4 was asked about the facility's process when an outside consultation was ordered by the physician. LVN 4 verified the licensed nurses will relay to the social services when a physician placed an order for an outside consultation to arrange the appointment. On 7/29/25 at 1018 hours, an interview and concurrent medical record review for Resident 54 was conducted with the SSD. The SSD verified when a physician placed an order for an outside consultation, the licensed nurses will communicate to the SSD who also involved the Case Manager with arranging the outside consultation appointments. The SSD verified the progress notes for Resident 54 dated 7/22/25, documented by the Case Manager showed the Case Manager had spoken with an outside facility to schedule an appointment with a urologist and for the Case Manager to follow-up if no response was received by 1800 hours on same day. The SSD also verified the Case Manager did not follow-up and should have called back to arrange the appointment regarding Resident 54's urology consult needed as ordered by the physician. On 7/29/25 at 1037 hours, an interview and concurrent medical record review for Resident 54 was conducted with the Case Manager. The Case Manager verified she assisted the SSD in scheduling outside facility consultation appointments. The Case Manager reviewed Resident 54's progress notes dated 7/22/25, showing the Case Manager contacted an outside facility confirming the eligibility of a consultation with a urologist and the outside facility advised the Case Manager to call back if no response was received by 1800 hours on the same day. The Case Manager acknowledged she did not call back and should have followed-up in scheduling a urology consult for Resident 54 as ordered by the physician. On 7/29/25 at 1608 hours, the Administrator, DON, and Clinical Resource were informed and acknowledged the findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and facility P&P review, the facility failed to properly conduct a post fall monitoring and communication for one of three residents (Resident 84) reviewed for accidents. * Resident 84's fall was not communicated to the dialysis center for continued monitoring. * Resident 84's post-fall neurological checks were not completed accurately and for the full 72 hours. These failures put the resident at risk for increased injury as well as a potential delay in the identification and provision of necessary interventions if the resident had any change in condition.Findings: Medical record review for Resident 84 was initiated on 7/22/25. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's Incident Note dated 6/19/25 at 0800 hours, showed the resident had a fall which resulted in a bump to the back of her head, and neurological checks were initiated. a. Review of Resident 84's Order Summary Report showed a physician's order dated 5/21/25, for dialysis appointments every Tuesday, Thursday, and Saturday at 0900 hours. Review of Resident 84's Nursing Facility Pre-Dialysis Assessment sheets dated 6/19/25, showed the form was to be completed and sent with the resident to the dialysis treatment. However, the form failed to show Resident 84 had a fall, for the dialysis center to be aware and could monitor the resident for any potential fall-related injuries while at the dialysis appointment. Review of Resident 84's Nursing Note dated 6/19/25 at 1532 hours, showed the resident left for her dialysis appointment at 0830 hours, and had returned to the facility at 1300 hours. Review of Resident 84's Progress Notes *NEW* failed to show if the facility had communicated the resident's fall to the dialysis center. Review of Resident 84's Transfer Out note dated 6/19/25 at 2018 hours, showed the resident was transferred to the acute care hospital. Review of Resident 84's Nurses Note dated 6/20/24 at 0345 hours, showed the resident returned to the facility with a diagnosis of a thoracic vertebrae fracture and a TLSO in place. On 7/24/25 at 0840 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 84's medical records and verified the resident record failed to show the resident's fall was communicated to the dialysis center, so the dialysis center could continue to monitor the resident for any fall-related injuries, as well as to use caution with the resident. b. Review of Resident 84's 72 Hours Neuro-Checklist initiated on 6/19/25 at 0800 hours, showed the following neurological checks were to be completed as scheduled:- every 30 minutes for two checks, written for 0830 and 0900 hours, then- every hour for three checks, written for 1200, 1500, and 1800 hours, then- every two hours for two checks, written for 2000, 2200 and 0000 hours, then - every four hours for four checks, written for 6/20/25 at 0400, 0800, 1200, and 1600 hours, then- every six hours for six checks, written for 2200 hours, on 6/21/25 at 0400, 1000, 1600, 2200 hours, and the last one on 6/22/25 at 0400 hours. The log showed Resident 84's neurological checks were not completed for the following date and times: - dated 6/19/25 at 0900 and 1200 hours, due to the resident being out of the facility for dialysis.- dated 6/19/25 at 2000, 2200, and 2400 hours, due to the resident being in the acute care hospital. Further review of 84's 72 Hours Neuro-Checklist showed the log's time schedule did not go up to the full 72 hours and was not scheduled accurately. Review of Resident 84's Nursing Note dated 6/19/25 at 1532 hours, showed the resident had left for the dialysis appointment at 0830 hours, and returned to the facility at 1300 hours. On 7/24/25 at 0840 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 84's medical record and verified the post-fall neurological checks were not completed per the facility's protocol when the resident returned from the dialysis center at 1300 hours. In addition, the DON verified the neurological checks were not conducted for the full 72 hours.

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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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 19 final sampled residents (Residents 24 and 95) were provided with the appropriate respiratory care when: * The facility failed to ensure Resident 24 received continuous oxygen at 2 LPM via nasal cannula as ordered by the physician. * The facility failed to change the oxygen tubing, nebulizer, and mask for Resident 95 per facility's protocols. These failures had the potential to negatively impact the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Oxygen Administration reviewed 2/2023 showed it is the policy of this facility that oxygen therapy is administered by licensed nurse as ordered by the physician or as a nursing measure and an emergency measure until the order can be obtained. The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. Medical record review for Resident 24 was initiated on 7/22/25. Resident 24 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 24’s H&P examination dated 7/8/25, showed the resident had the capacity to understand and make decisions. Review of Resident 24’s Order Summary Report dated 7/24/25, showed a physician’s order dated 7/14/25, for continuous oxygen at 2 LPM via nasal cannula/mask to keep the oxygen saturation above 90% every shift related to COPD. On 7/24/25 at 0756 hours, an observation and concurrent interview was conducted with Resident 24. Resident 24 was observed without oxygen via nasal cannula. Resident 24’s nasal cannula was observed inside a set up bag. The oxygen was on 2 LPM and the nasal cannula was connected to the oxygen concentrator. Resident 24 stated a staff was with him when he removed his nasal cannula. On 7/24/25 at 0801 hours, an observation and concurrent interview for Resident 24 was conducted with LVN 4. LVN 4 verified Resident 24 was not receiving oxygen via nasal cannula. LVN 4 acknowledged the nasal cannula was inside the set-up bag and Resident 24 would not be able to reach the nasal cannula. LVN 4 administered the oxygen at 2 LPM via nasal cannula to Resident 24. On 7/24/25 at 0808 hours, an observation of Resident 24 and concurrent interview was conducted with Resident 24 and LVN 4. Resident 24 stated he took out his oxygen at 0630 hours and a staff was with him. Resident 24 denied SOB. LVN 4 checked Resident 24's oxygen saturation level and the oxygen saturation result was 75%. LVN 4 stated he would be calling his supervisor and Resident 24’s physician. On 7/24/25 at 0817 hours, LVN 4 was observed applying a non-rebreather mask at 15 LPM to Resident 24. On 7/24/25 at 0820 hours, RN 1 was observed auscultating Resident 24’s chest and checking the oxygen saturation level. RN 1 stated Resident 24’s oxygen saturation was 99% while receiving oxygen via non-rebreather mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/25 at 1031 hours, an observation and concurrent interview for Resident 24 was conducted with CNA 4. CNA 4 stated he was not sure if Resident 24 had an oxygen when he saw Resident 24 this morning. CNA 4 stated Resident 24 sometimes removed his oxygen and the resident put it back on. CNA 4 stated he asked Resident 24 to put back the oxygen if he saw him without oxygen. On 7/24/25 at 1131 hours, an interview was conducted with LVN 4. LVN 4 stated he saw Resident 24 at 0710 hours and did not notice if the resident had an oxygen via nasal cannula or not. LVN 4 stated Resident 24 was sent to the acute care hospital via 911 because the resident’s oxygen saturation level could not keep up to 90% even with the breathing treatment and receiving oxygen via nasal cannula. On 7/24/25 at 1142 hours, an interview was conducted with RN 1. RN 1 stated Resident 24 was transferred to the acute care hospital via 911 at 1104 hours. RN 1 stated Resident 24 remained alert and responsive. RN 1 stated Resident 24 was on oxygen at 10 LPM via nonrebreather mask and the oxygen saturation was 98%. RN 1 stated Resident 24’s oxygen saturation at around 0930 hours was at 84% and the resident was on 5 LPM of oxygen. RN 1 further stated the staff were not able to stabilize Resident 24’s oxygen saturation and informed the resident they would not be able keep him in the facility because of the desaturation. RN 1 stated Resident 24 initially refused but eventually agreed to be transferred to the acute care hospital. RN 1 stated Resident 24’s physician ordered the transfer and she called 911 at 1040 hours. On 7/24/25 at 1659 hours, a telephone interview was conducted with CNA 5. CNA 5 stated Resident 24 removed his nasal cannula and asked him to put the nasal cannula in the set-up bag before he changed the resident’s diaper at around 0630 hours. CNA 5 stated he responded to a bed alarm in another room after he finished changing Resident 24’s diaper. CNA 5 stated he told Resident 24 before he left the room to press the call light button so the charge nurse could put back the resident’s nasal cannula. CNA 5 stated he forgot to tell another CNA or a licensed nurse about the nasal cannula because he answered a bed alarm in the other room. On 7/25/25 at 1350 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the CNA should have told someone or other staff about Resident 24’s nasal cannula being kept in the set-up bag. The DON stated Resident 24 was alert and would be able to make needs known by using the call light. 2. Review of the Facility’s P&P titled Disposition of Respiratory Equipment Disposables dated 8/2019 showed supplies will be clearly dated when initially set up or changed weekly. Medical record review of Resident 95 was initiated on 7/22/25. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95's Order Summary Report dated 7/28/25, showed a physician's order dated 4/29/25, to administer Ipratropium-Albuterol (medication to relieve difficulty breathing) Inhalation Solution 0.5-2.5 (3) mg/3 ml (Ipratropium-Albuterol), one vial to be inhaled orally every four hours as needed for shortness of breath/wheezing. On 07/22/25 at 0750 hours, Resident 95 was observed to have breathing treatment equipment at the resident's bedside table, including the oxygen tubing, mask, and nebulizer, bagged and dated 4/20/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at 0830 hours, an observation and concurrent interview for Resident 95 was conducted with LVN 1. Resident 95 was observed having breathing treatment equipment at the resident's bedside table, including the oxygen tubing, mask, and nebulizer, bagged and dated 4/20/25. LVN 1 stated they should have changed it weekly, and Resident 95 had an active physician's order for breathing treatment nebulizer as needed. LVN 1 verified the findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being for two of two final sampled residents (Residents 50 and 95) reviewed for pain management. * The facility failed to ensure the nonpharmacological interventions, and its effectiveness were consistently documented prior to the administration of the acetaminophen (pain medication) for Resident 50. In addition, the facility failed to document the complete pain assessment as per the care plan for Resident 50. * The facility failed to document the complete pain assessment, as per the care plan for Resident 95. These failures have the potential to put Residents 50 and 95 at risk for the resident's pain being improperly managed.Findings: Review of the facility’s P&P titled Recognition and Management of Pain revised 7/2017 showed it is the policy of the facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident’s goals and preferences. The Care Plan will include preventive or care interventions (pharmacological and nonpharmacological) for any resident admitted with pain. The Interdisciplinary Care Plan will reflect the location and type of pain, pharmacological and no-pharmacological interventions, with evaluation and revision as indicated. 1. Medical record review for Resident 50 was initiated on 7/22/25. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50’s H&P examination dated 4/11/25, showed Resident 50 had the capacity to understand and make decisions. Review of Resident 50’s Order Summary Report dated 7/24/25, showed the following physician’s orders: - dated 4/10/25, to implement the nonpharmacological interventions for pain as needed. To document 1-repositining, 2-dim light/quiet environment, 3-relaxation, 4- distraction, 5-music, 6-massage. - dated 5/29/25, to administer acetaminophen 500 mg, two tablets by mouth every six hours as needed (PRN) for pain management. Review of Resident 50’s plan of care showed a care plan problem dated 4/10/25, addressing Resident 50’s acute/chronic pain. The interventions included administering the analgesia medication as per the physician's orders, to monitor/document the probable cause of each pain episode, and to monitor/record the pain characteristics: quality (e.g. sharp, burning), severity (1 to 10 scale), anatomical location, onset, duration (e.g. continuous, intermittent), aggravating factors, relieving factors. Review of Resident 50’s MAR for 7/2025 showed Resident 50 was administered the acetaminophen 500 mg two tablets by mouth every six hours as needed for pain management on the following dates: - on 7/2/25 at 2057 hours, for a pain level of 3 (on a 0 to 10 pain scale, 0 = no pain and 10 = worst pain). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 7/4/25 at 0209 and 2126 hours, 7/18/25 at 0124 hours, 7/20/25 at 0241 hours, 7/21/25 at 0326 hours, 7/22/25 at 1912 hours, and 7/23/25 at 0300 hours, for a pain level of 3. - on 7/6/25 at 0306 hours, 7/14/25 at 1550 hours, 7/18/25 at 2134 hours, and 7/20/25 at at 1846 hours, for a pain level of 4. - on 7/23/25 at 1550 hours, for a pain level of 5. Further review of Resident 50’s MAR for 7/2025 showed the documentation of the nonpharmacological pain interventions implemented and its effectiveness for the ordered PRN medication on the following dates and times: - on 7/4/25 at 0140 hours, - on 7/6/25 at 0230 hours, and - on 7/20/25 at 0210 hours. Review of Resident 50’s Progress Notes for 7/2025 failed to show the documentation of the nonpharmacological pain interventions attempted and its effectiveness prior to the administration of the pain medication for the above dates, when the acetaminophen pain medication was administered. Additionally, further review of the Progress Notes failed to show the documentation of the pain assessment conducted for Resident 50’s pain (including the pain location, quality, characteristics, and alleviating/aggravating factors) prior to the administration of the acetaminophen pain medication for the above dates. On 7/28/25 at 1343 hours, an interview and concurrent medical record review for Resident 50 was conducted with LVN 2. LVN 2 stated when the residents complained of pain, the licensed nurse assessed the resident’s pain to determine the pain scale, location, characteristics, and the alleviating/aggravating factors and would document the pain assessment in the progress notes. LVN 2 stated the nonpharmacological pain interventions would be implemented and its effectiveness would be documented in the MAR. LVN 2 stated if the nonpharmacological interventions implemented were ineffective, then the ordered pain medication would be administered. LVN 2 stated Resident 50 usually complained of pain in her back or legs and had the acetaminophen medication for pain. LVN 2 reviewed Resident 50’s medical record and verified the above findings. On 7/29/25 at 1100 hours, an interview was conducted with the DON. The DON stated when the resident reported pain, the licensed nurse was expected to assess the resident’s pain: pain scale, location, and characteristics, and should implement the nonpharmacological pain interventions. The DON stated the licensed nurses were expected to document the pain assessment whenever the resident reported pain, and the nonpharmacological interventions would be implemented and its effectiveness or ineffective would be documented. The DON stated if the nonpharmacological interventions implemented were ineffective, then the PRN pain medication would be administered as per the physician’s order. On 7/29/25 at 1122 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review of Resident 95 was initiated on 7/22/25. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 95’s Order Summary Report dated 7/28/25, showed a physician order dated 5/29/25, for hydrocodone-acetaminophen (pain medication) oral tablet 5-325 mg. The order was to give one tablet by mouth every six hours as needed for moderate (pain level of 4 - 6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst pain) to severe pain (pain level of 7 to 10). Review of Resident 95’s care plan dated 4/29/25, addressed the acute/chronic pain related to chronic physical disability and disease process. The interventions included monitoring and recording the pain characteristics: quality (e.g., sharp, burning), severity (using the pain scale of 1 to 10), anatomical location, onset, duration (e.g., continuous, intermittent), aggravating factors, and relieving factors. Review of Resident 95’s MAR for July 2025 showed the following: - dated 7/5/25, the pain level was 7. However, there was no documentation of the location and pain characteristics. - dated 7/8 and 7/22/25, the pain level was 6, with generalized body pain. However, there was no documentation of the pain characteristics. - dated 7/14/25, the pain level was 5, with generalized body pain. However, there was no documentation of the pain characteristics. - dated 7/21/25, the pain level was 7, with generalized body pain. However, there was no documentation of the pain characteristics. - dated 7/23 and 7/24/25, the pain level was 8, with generalized body pain. However, there was no documentation of the pain characteristics. - dated 7/25/25, the pain level was 4. However, there was no documentation of the location and pain characteristics. On 7/29/25 at 1030 hours, an interview and concurrent medical record review for Resident 95 was conducted with RN 1. RN 1 stated before the licensed nurse administered a pain medication, they should have assessed the pain location and characteristics, including onset, quality, etc., and documented the findings in the e-MAR progress notes. RN 1 verified the findings. On 7/29/25 at 1130 hours, the DON was informed of the above findings. The DON stated the licensed nurse should have documented the pain location and characteristic when they administered the pain medication. The DON verified the above findings.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the competency of two licensed nurses (LVNs 7 and 8) and the DSD interviewed regarding the facility's glucometer operation and protocols. * LVNs 7 and 8, and the DSD were not aware of how long the glucose control solutions used to do Quality Control checks for the glucometers are good for from the date they were opened. In addition, LVNs 7 and 8, and the DSD were not able to verbally state the facility's protocol on when to conduct the quality control checks and the process to conduct quality control checks for the glucometer. These failures had the potential of not providing care to the residents in a safe and competent manner. Findings: Review of the facility's P&P titled Performance Evaluations revised 7/2010 showed it is the policy of the company that employees are to be given regular performance evaluations. The Supervisor/Department Head will evaluate the employee's performance using the applicable performance evaluation form. Review of the glucometer manufacturer's manual titled Assure Platinum Blood Glucose Monitoring System User Instruction Manual (undated) showed under When to Perform a Control Solution Test:- Before testing with the Assure Platinum System glucometer for the first time- When you open a new bottle of test strips- Whenever you suspect the meter or test strips may not be functioning properly- If test results appear to be abnormally high or low or are not consistent with clinical symptoms- Use the control solution within 90 days (3 months) of first opening On 7/24/25 at 1425 hours, an inspection of Medication Cart 1, a concurrent interview, and facility document review was conducted with LVN 7. LVN 7 stated the glucometer, test strips, and supplies had been replaced on her cart the day before. The Quality control (QC) test results were not available in the glucometer history and were not documented on the facility document titled Quality Control Record dated July 2025. When asked LVN 7 was unable to verbalize the facility protocol of when it was appropriate to conduct a QC test, the process for completing the Quality Control Record, or the life of test streps and control solutions once opened. LVN 7 stated she was unaware of the protocol and needs an in-service on glucometer protocols. On 7/29/25 at 1019 hours, an interview and concurrent facility staff in-service training record review for LVNs 7 and 8 was conducted with the DSD. The DSD provided documentation of LVNs 7 and 8 receiving an in-service on 6/7/24, titled Quality Control Assure Blood Glucose Machine. The course content was listed as testing blood glucose for high/low solutions for proper calibration for accuracy. Additionally, LVNs 7 and 8 were tested for skills competency on blood glucose testing on 11/14/24. The competency form showed LVN 7 and LVN 8 passed the competency. When the DSD was asked if the staff were instructed during the training about the life of the test strips and the control solutions once opened for Quality Control checks on the glucometer, the DSD stated the test strips were good for 30 days the the staff were supposed to look at the expiration date. On 7/29/25 at 1054 hours, an interview was conducted with LVN 8. When asked about the facility's process regarding Quality Control checks for the glucometer, LVN stated the facility conducted Quality Control checks when they get new glucometer machine; however, he was not sure about the Quality Control checks with the new testing strips. LVN 8 stated the new testing strips needed to be logged in the book, and a new page for the Quality Control checks needed to be started for a new glucometer machine. LVN also stated the testing strips were good for 30 days after opening. LVN 8 also stated the control solution once opened was good for 30 days. Further review of the in-service training records showed on 7/24/25, an additional in-service titled Quality Control Blood Glucose Machine was conducted by the facility. The in-service was presented by the DSD with LVNs 7 and 8 in attendance. However, when the staff were interviewed regarding the facility's process for Quality Control checks for glucometer, the DSD, and LVNs 7 and 8 were unable to accurately verbalize facility protocol on when to conduct a Quality Control check, the process for completing the Quality Control Record, or the life of test strips and control solutions once opened. On 7/29/25 at 1248 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview, personnel file review, and facility P&P review, the facility failed to ensure the annual skill performance evaluations for three of three staff members (CNAs 1, 2, and 3) reviewed were complete. This failure had the potential for the residents to not receive the proper and safe care. Findings: Review of the facility's P&P titled Nursing Staff Competency dated 2/2019 showed the facility will conduct an annual skills fair or equivalent to facilitate the completion of skills and competency evaluations. Validation of all the skills is required, as per the Orientation and Skills Check form. 1. Review of CNA 1's Comprehensive Clinical Competency form was initiated on 7/23/25. CNA 1 was hired on 2/2/11. Review of CNA 1's Comprehensive Clinical Competency form dated 11/14/24, showed the sections for Team Lead (Safety/Disaster), emergency crash cart location, knowledge of the emergency shut-offs location, emergency evacuation plan, emergency operations plan (EOP): fire, disaster, and emergency procedures, and hazard communication: SOS-Safety Data Sheets. However, the sections failed to show if the competency trainings were Met or Not Met. Further review of the form under the last section for the CNA Comprehensive Clinical Competency Review-Skills Check Requirement, showed the Met or Not Met was not indicated and the next reevaluation schedule was left blank. 2. Review of CNA 2's Comprehensive Clinical Competency form was initiated on 7/23/25. CNA 2 was hired on 4/2/08. Review of CNA 2's Comprehensive Clinical Competency dated 11/14/24, showed the sections for Admission, Transfer, and Discharge and Team Leader (Safety/Disaster). However, the sections failed to show if the competency trainings were Met or Not Met. Further review of the form under the last section for CNA Comprehensive Clinical Competency Review-Skills Check Requirement, the Met or Not Met was not indicated and the next reevaluation schedule was left blank. 3. Review of CNA 3's Comprehensive Clinical Competency form was initiated on 7/23/25. CNA 3 was hired on 1/2/97. Review of CNA 3's Comprehensive Clinical Competency form dated 11/14/24, showed the sections for Culture/Customer Services and Policy of Human Resources and Team Lead (Safety/Disaster). However, these sections failed to show if the trainings were Met or Not Met. Further review of the form under the last section for the CNA Comprehensive Clinical Competency Review-Skills Check Requirement, showed the Met or Not Met was not indicated. On 7/24/25 at 0840 hours, the DSD stated all the sections of the clinical competency form should have been documented as ‘Met or Not Met. The last section for the skills checks requirement should have been answered as Met or Not Met, and the reevaluation date should have been documented. The DSD acknowledged the CNAs annual skill check performance forms were incomplete.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the medication was administered as ordered by the physician for one of two residents (Resident 84) investigated for dialysis. * The facility failed to administer Resident 84's furosemide (a diuretic medication) as per the physician's order. This failure had the potential for the resident to have an adverse outcomes related to the diuretic not being administered as ordered. Findings: Medical record review for Resident 84 was initiated on 7/22/25. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's Order Summary Report showed the following physician's order:- dated 5/21/25, for the resident's dialysis appointments every Tuesday, Thursday, and Saturday at 0900 hours,- dated 11/6/24, to hold all the blood pressure medications prior to dialysis on Tuesdays, Thursdays, and Saturdays, and - dated 11/14/25, for furosemide 40 mg by mouth daily for edema (swelling). Review of Resident 84's MAR for July 2025 showed a documentation of 2 (hold/see nurses note) on Resident 84's furosemide on 7/10 and 7/22/25 at 0900 hours. Review of Resident 84's eMAR-Medication Administration Notes showed the following:- dated 7/10/25 at 0947 hours, the furosemide was held due to all the blood pressure medications were to be held on dialysis days, and- dated 7/22/25 at 1012 hours, the furosemide was held due to dialysis. On 7/24/25 at 0840 hours, an interview and concurrent record review was conducted with the DON. The DON reviewed Resident 84's medical record and verified the furosemide was held on 7/11 and 7/22/25. The DON stated the resident's furosemide medication was not indicated for the blood pressure as per the physician's order, the furosemide medication should have been administered to the resident on those days.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the pharmacist consultant performed a monthly MRR (Medication Regimen Review) to identify potential irregularities for two of five sampled residents (Residents 4 and 7) reviewed for unnecessary medications. * The facility failed to ensure Resident 4 had a monthly MRR completed by the pharmacist consultant for May 2025. * The facility failed to ensure Resident 7's MRR for June and July 2025 conducted by the pharmacist consultant addressed the use of two antidepressant medications (mirtazapine and bupropion) for the same manifested behavior of verbalization of sadness. These failures put the residents at risk for adverse outcomes related to the medications the residents were receiving. Findings: Review of the facility’s P&P titled Medication (Drug) Regiment Review (MRR) reviewed January 2022 showed the pharmacist will review each resident's medication regimen at least once a month to identify irregularities and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications 1. Medical record review for Resident 4 was initiated on 7/22/25. Resident 4 was admitted to the facility on [DATE]. Review of the facility’s MRR binder failed to show the pharmacist consultant conducted a MRR for Resident 4 for May 2025. Review of the May 2025’s MRR Current Resident Listing showed a list of the residents’ medication regimens reviewed by the pharmacist consultant. Resident 4’s name was not included on the list. On 07/25/25 at 1033 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON stated the pharmacist consultant should do a MRR on all the residents at the facility every month. The DON verified Resident 4 was admitted at the facility for the entire month of May 2025 and should have had a MRR conducted by the pharmacist consultant. The DON also reviewed May 2025's MRR and verified Resident 4 was not listed as having been reviewed by the pharmacist consultant. 2. Medical record review for Resident 7 was initiated on 7/22/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's Order Summary Report dated 7/24/25, showed a physician's order dated 5/8/25, for Remeron oral tablet 7.5 mg (mirtazapine), to be given one tablet by mouth once a day for depression manifested by episodes of verbalization of sadness. In addition, Resident 7 had a physician's order written on the same date for bupropion hydrochloride extended release (XL) oral tablet Extended Release 24 Hour 150 mg (bupropion HCl), to be given one tablet by mouth once a day for depression manifested by verbalization of feeling sad. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/25 at 1620 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON was asked if the pharmacist consultant conducted a MRR to address the resident's use of two antidepressant medications for the same behavior manifested by feeling sad. The DON verified a MRR was conducted by the pharmacist consultant for June and July 2025; however, the facility was not able to provide documentation the pharmacist addressed the use of two antidepressants (mirtazapine and bupropion) as ordered by the physician, for the same behavior manifestations of verbalization of feeling sad. Furthermore, the DON verified there was no pharmacy recommendations received from the MRR conducted by the pharmacist consultant for June and July 2025 for Resident 7. The DON verified the findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.14%. One of the two licensed nurses (LVN 7) observed during the medication administration was found to have made errors. * LVN 7 failed to ensure the sevelamer medication (phosphate binder) was administered to Resident 84 on time and with a meal as per the physician's orders. LVN 7 failed to ensure the furosemide medication (diuretic) was administered to Resident 84 as ordered. These failures created the risk for the resident to have potential side effects or complications related to the medications.Findings: Review of the facility's P&P titled Administration of Medications (undated) showed the following:- Medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant.- Medications must be administered in accordance with the written orders of the attending physician.- Unless otherwise specified by the resident's attending physician, routine medications will be administered per the facility time ranges. On 7/24/25 at 0827 hours, a medication administration observation for Resident 84 was conducted with LVN 7. LVN 7 prepared and administered Resident 84's medications which included the following:- sevelamer (phosphate binder) 800 mg two tablets- vitamin D (supplement) 25 mcg one tablet- docusate sodium (stool softener) 250 mg one tablet- lidocaine patch (topical pain relief) 4% one patch to left shoulder- Rena Vite (supplement) one tablet- Letrozole (antiestrogen) 2.5 mg one tablet- Miralax (laxative) 17 gm- allopurinol (reduces uric acid) 100 mg one tablet- fish oil (supplement) 500 mg two tablets LVN 7 administered the sevelamer tablets to Resident 84 at 0842 hours. LVN 7 stated Resident 84 ate breakfast in her room between 0730 and 0800 hours. Medical record review for Resident 84 was initiated on 7/22/25. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's Order Summary Report dated 7/23/25, showed the following physician's orders:- dated 11/14/24, for furosemide oral tablet 40 mg one tablet by mouth one time a day for edema- dated 1/24/25, for sevelamer HCl oral tablet 800 mg two tablets by mouth with meals for phosphate binder. LVN 7 was not observed preparing the furosemide oral tablet 40 mg medication during the medication pass observation, and the sevelamer was administered at 0842 hours, without meals. On 7/24/25 at 1342 hours, an interview and concurrent medical record review for Resident 84 was conducted with LVN 7. LVN 7 reviewed Resident 84's active medication orders. LVN 7 verified she did not administer the sevelamer medication to Resident 84 on time and with her meals. Additionally, LVN 7 verified she did not administer the furosemide 40 mg tablet medication. LVN 7 stated she held Resident 84's furosemide 40 mg because she knew it could lower the blood pressure before the dialysis and should have clarified with the physician because the indication for the furosemide was for edema, and not hypertension. On 7/29/25 at 1200 hours, an interview and concurrent medical record review for Resident 84 was conducted with the DON. The DON reviewed Resident 84's active medication orders. The DON verified the sevelamer should have been given according to the physician's orders and the furosemide should not have been held because the indication was for edema.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage, labeling, and disposal of medications. * The facility failed to ensure the expired medications were removed from the Medication Room. In addition, the facility failed to ensure medications used for different routes were not stored together in one container, and the medications were labeled. * The facility failed to ensure the expired medications were removed from Medication Carts B and C. * The facility failed to ensure the supplies were labeled for Medication Cart C. * The facility failed to ensure the three sachets of Calazinc body shield (skin protectant) were not kept at Resident 24's bedside. These failures posed the potential risk for the residents to receive the expired medications and treatments, and for the unauthorized access to unsecured supplies.Findings: Review of the facility's P&P titled Medication Storage in the Facility (undated) showed medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or designated administrative personnel. Further review of the P&P showed outdated, contaminated, or deteriorated medications and those in containers that are disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exits. Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified. 1. On 7/23/25 at 0951 hours, an inspection of the Medication Room and concurrent interview was conducted with RN 1. During the inspection of the Medication Room, the following was identified: - Four boxes of acetaminophen (medication to relieve pain and reduce fever) suppositories containing 12 rectal suppositories in each box, with expiration date of 7/2024.- Six culture swabs with expiration date of 6/27/25.- Inside the medication refrigerator, a medication bin contained two of the brimonidine (eye drop medications to treat glaucoma and ocular hypertension) 0.2% medication, dorzolamide (eye drop medications to treat elevated intraocular pressure in individuals with open-angle glaucoma or ocular hypertension) HCL (hydrochloride) 2%, two of the timolol maleate (eye drop medications to lower the pressure in the eye by reducing the build up of fluid) 0.25% medications. The identified eye drops were stored in the same bin with the insulin glargine (a long acting insulin medication injected to individuals diagnosed with type 1 and 2 diabetes, and Retacrit (medication injected to individuals to treat anemia).- Two boxes of Trulicity (an injectable medication to treat type 2 diabetes). One box contained four single dose pens with no label; one box with no discard/expiration date. RN 1 acknowledged and verified all of the above findings. 2. On 7/24/25 at 1423 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 1 and the IP. During the inspection of Medication Cart B, the following was identified: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Tegaderm (transparent adhesive film dressing used for wound care or to protect medical device sites) film with an expiration date of 3/26/25.- A box containing 23 surgical masks with an expiration date of 1/14/25.- 16 medical face masks ear-loop with eye shield with an expiration date of 5/31/24. RN 1 and the IP acknowledged and verified all of the above findings. 3. On 7/24/25 at 1429 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 2. During the inspection of Medication Cart C, the following was identified: - Two boxes of Molnlycke Mefix self-adhesive fabric. One box with full roll of tape, and the other box with the roll almost finished had expiration date of 1/28/25.- 74 pieces of the Telfa (type of non-adherent wound dressing) adhesive dressings with an expiration date of 1/2025.- 100 ml bottle of normal saline. The cap showed date opened 7/24/25, with no documentation of the time the bottle was opened. LVN 2 stated the bottle was good for 24 hours after it was opened and she opened the bottle at approximately 0900 hours. LVN 2 acknowledged and verified all of the findings. 4. Review of the facility's P&P titled Medication Access and Storage revised 2/2019 under the Procedure section showed only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, medication and treatment carts, and medication supplies are locked or attended by persons with authorized access. On 7/22/25 at 1013 hours, during the initial tour of the facility, Resident 24 was observed lying in bed with eyes closed. Three sachets of Calazinc body shield was observed on top of Resident 24’s bedside cabinet. Medical record review for Resident 24 was initiated on 7/22/25. Resident 24 was admitted to the facility on [DATE], and readmitted on [DATE] . Review of Resident 24’s H&P examination dated 7/8/25, showed the resident had the capacity to understand and make decisions. Review of Resident 24’s Order Summary Report dated 7/24/25, showed the following physician’s order: - dated 7/8/25, for the right posterior thigh MASD: cleanse with normal saline, pat dry, apply Calazinc, and cover with dry dressing daily for 21 days then re-evaluate; and - dated 7/8/25, for the coccyx area Stage 2 pressure injury: cleanse with normal saline, pat dry, apply Calazinc, and cover with dry dressing daily until further order. On 7/22/25 at 1103 hours, an observation and concurrent interview was conducted with Resident 24. Resident 24 was asked about the three sachets of the Calazinc body shield cream on top of his bedside cabinet. Resident 24 stated the staff applied the Calazinc body shield cream between his legs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at 1108 hours, an observation and concurrent interview for Resident 24 was conducted with CNA 4. CNA 4 verified there were three sachets of Calazinc body shield cream on top of Resident 24's bedside cabinet. CNA 4 stated the Calazinc body shield cream should have been in the treatment cart. On 7/24/25 at 1047 hours, an interview and concurrent medical record review for Resident 24 was conducted with LVN 6. LVN 6 acknowledged the findings. LVN 6 stated the treatment nurse or the charge nurse applied the Calazinc body shield cream to Resident 24 as ordered by the physician. LVN stated Resident 24’s Calazinc body shield cream should not be on the bedside and should be in the treatment cart. On 7/25/25 at 1410 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have kept Resident 24’s Calazinc body shield cream in the treatment cart.

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F 0773 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the laboratory services for one of five final sampled residents (Resident 71) reviewed for unnecessary medication. The facility failed to schedule the laboratory testing as ordered by the physician for Resident 71. This failure had the potential for Resident 71's laboratory test to be missed and adversely affect the resident's physical health and well-being. Findings: Review of the facility's P&P titled Lab Procedure revised 5/2007 showed the physician ordered labs will be handled in a proficient manner to ensure timeliness, accuracy, and proper follow-up. When receiving an order for monthly, quarterly, bi-annually, or annual lab, complete the standing order change form. Medical record review for Resident 71 was initiated on 7/22/25. Resident 71 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of Type 2 Diabetes Mellites, with unspecified complications. Review of Resident 71's Consultant Pharmacist's MRR for recommendations between 4/1 and 4/18/25, showed the Consultant Pharmacist documented Resident 71's fingerstick readings showed very high blood sugars, mainly greater than 200 mg/dl on most occasions. The Consultant Pharmacist recommended contacting the physician to adjust Resident 71's diabetic therapy and to continue the quarterly A1c levels. Review of Resident 71's Order Summary Report dated 7/23/25, showed a physician's order dated 5/1/25, to obtain Resident 71's A1C levels every three months. Review of Resident 71's Laboratory Results Report dated 4/3/25, showed Resident 71's A1c level was 7.3%, with a reference range of 4.6-5.6%. On 7/28/25 at 1130 hours, an interview and concurrent medical record review for Resident 71 was conducted with RN 1. RN 1 stated when the physician ordered laboratory testing for the residents' A1c level for every three months, the order would be entered into the system as a routine order, for every three months from the ordered date. RN 1 stated the licensed nurse who received the order was also responsible for scheduling the future/pending laboratory tests through Laboratory 1, for the next six months. RN 1 reviewed Resident 71's medical record and stated Resident 71 should have a pending laboratory test scheduled for 8/1/25 for Resident 71's A1c level. RN 1 reviewed Resident 71's pending laboratory orders for Laboratory 1 and stated Resident 1 had no pending/future laboratory tests scheduled and there was a potential for the laboratory test to be missed. On 7/29/25 at 1100 hours, an interview was conducted with the DON. The DON stated for the routine laboratory tests, the licensed nurse who received the physician's order was expected to enter the laboratory order as a routine order for every three months, and was also responsible for informing the laboratory of the routine laboratory order, either by calling or by completing a laboratory requisition. On 7/29/25 at 1122 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen when: * The facility failed to ensure the kitchen staff were wearing hair restraints and clothing that covers body hair. * The facility failed to ensure the pitchers and pitcher covers were properly air dried. * The facility failed to ensure one of the multiple pitchers was clean and free of particle. * The facility failed to ensure the sanitary condition of the kitchen hood over the stove was maintained. These failures had the potential to cause foodborne illnesses in a highly susceptible residents population of 88 facility residents who consumed food prepared in the kitchen.Findings: Review of the facility's document titled Diet Type Report dated 7/22/25, showed 88 of 90 residents in the facility received food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 2-402.11 Effectiveness, (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Review of the facility's P&P titled Dress Code dated 2023 under the Proper Dress section, showed the following:- Hat for hair, if hair is short,- Hair net for hair if hair is long, and- Beards and mustache (any facial hair) must wear beard restraint. a. On 7/22/25 at 0802 hours, an observation of Dishwasher 1 and concurrent interview was conducted with the Kitchen Manager. Dishwasher 1 was observed walking in the kitchen towards the dishwashing area without a hair cover. The Kitchen Manager verified Dishwasher 1 had no hair restraint. The Kitchen Manager stated Dishwasher 1 shaved his head. The Kitchen Manager acknowledged Dishwasher 1's hair grew back and had very short hair. On 7/22/25 at 0805 hours, an observation and concurrent interview was conducted with the CDM (Certified Dietary Manager) inside the kitchen. The CDM acknowledged the above findings. In addition, the CDM was observed with beard but not wearing a beard restraint. The CDM verified he was not wearing beard restraint and stated he needed to shave. b. On 7/23/25 at 1015 hours, an observation of the pureed biscuit food preparation by [NAME] 1 and concurrent interview was conducted with the CDM. [NAME] 1 had black hairy forearms which were uncovered during the puree food preparation. The CDM was asked about the facility process regarding body hair like hairy arms. The CDM stated he would check the facility's P&P. On 7/24/25 at 0953 hours, a follow-up interview was conducted with the CDM. The CDM verified and stated the facility's policy showed to wear hat or hair net, face covering for beard and mustache, and clothing to cover the body hair. 2. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required, showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. Review of the facility's P&P titled Dishwashing dated 2023 under the Procedure section, showed the dishes are to be air dried in racks before stacking and storing. On 7/22/25 at 0813 hours, during the initial tour of the kitchen, multiple white pitchers were observed stacked with blue covers on a tray without drying mesh. In addition, the white pitchers and blue covers of the pitcher were wet. The CDM was made aware and verified the findings. 3. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's P&P titled Sanitation dated 2023 under the Procedure section, showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. On 7/22/25 at 0813 hours, during the initial tour of the kitchen, one of the multiple white pitchers had an orange particle inside. The CDM verified the findings and put away the dirty pitcher on a cart with the dishes to be cleaned. 4. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. Exhaust ventilation hood systems in food preparation and warewashing areas including components such as hoods, fans, guards, and ducting shall be designed to prevent grease or condensation from draining or dripping onto food, equipment, utensils, linens, and single-service, and single-use articles. Review of the facility's P&P titled Hoods, Filters, and Vents dated 2023 showed the hoods must be cleaned every two weeks and must be free of dust and grease. On 7/22/25 at 0818 hours, during the kitchen tour, a concurrent observation and interview was conducted with the CDM

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F 0813 Level of Harm - Potential for minimal harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the safe food handling guidelines for the food brought in by families/visitors were implemented for one of 19 final sampled residents (Resident 95). * The facility failed to ensure the food brought in by families/visitors for Resident 95 were labeled. This failure had the potential to result in unsafe food handling and could cause foodborne illnesses in residents who received food brought in by families/visitors.Findings: Review of the facility's P&P titled Foods Brought by Family or Visitor dated 7/21/21, showed that non-perishable foods are those that do not require time and temperature control refrigeration for food safety. These may be stored in the resident's room. They will be labeled with the resident's name, location, and date. These foods shall be discarded according to facility dry/produce storage standards, manufacturer best by or use by dates, or no more than 30 days. Medical record review of Resident 95 was initiated on 7/22/25. Resident 95 was admitted to the facility on [DATE], and readmitted on [DATE]. On 7/22/2025 at 0750 hours, an observation was conducted in Resident 95's room. Resident 95 was observed to have a plastic round container containing crackers on the bedside table. The container was not labeled and dated. On 07/22/2025 at 0830 hours, an observation and concurrent interview was conducted with Resident 95 and LVN 1. LVN 1 verified Resident 95's plastic container with crackers was unlabeled. Resident 95 stated her family brought the container of crackers last week. LVN 1 acknowledged the findings and stated they should have labeled and dated the container of crackers upon admission.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, facility document review, and facility P&P review, the facility failed to establish and maintain an infection control program designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the monthly infection surveillance documents were summarized and analyzed accurately reflect the total number of CAI (Community-Acquired Infection) in the facility for April and May 2025. * The facility failed to develop a water management program which included the process to identify, test, and prevent Legionella (a bacteria which can cause a serious type of lung infection) and other opportunistic waterborne pathogens. In addition, the failure to accurately analyze the data from the infection surveillance log for the months of April and May 2025 resulted in incorrect information for the facility's mapping and infection control minutes regarding the CAI in the facility. These failures had the potential for increased risk of infections and compromising the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Plan (undated) showed the objective of this requirement is for the facility to develop a comprehensive Infection Control Policy that establishes a facility-wide system for the prevention, identification, investigation and control of infections of residents, staff and visitors that is based upon facility assessment, best practices and regulatory compliance for the goal of quality systems for care. A collaborative effort between the facility leadership, employees, resident/resident representative, facility staff, Medical Director, and pharmacist is essential for success of the infection Prevention and Control Program. It is the policy that this facility's Infection Prevention and Control Program is based upon information from the Facility Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. The Infection Prevention and Control Program includes a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to regulatory requirements and following accepted national standards. Further review of the facility's P&P showed the elements of the infection prevention and control plan include written standards, policies, and procedures for the Infection Prevention and Control program which include (among others listed) surveillance: a system of surveillance designed to identify possible communicable diseases or infection before they can spread to other persons in the facility. Review of the facility's form titled Prevention and Control Surveillance Log for 4/2025 showed a total of 31 CAI and 10 HAI (Healthcare-Associated infection). However, when the total number of infections were counted from the log, the total number of CAI in the surveillance log was 32. Review of the facility's form titled Prevention and Control Surveillance Log for 5/2025 showed a total of 20 CAI and 12 HAI. However, when the total number of infections were counted from the log, the total number of CAI in the surveillance log was 21. Review of the facility's Infection Prevention and Control Meeting Minutes dated 5/27/25, for April 2025 showed the facility had a report for April 2025 with 31 CAI. Review of the facility's Infection Prevention and Control Meeting Minutes dated 6/26/25, for May 2025 showed the facility had a report for May 2025 with 20 CAI. Review of the facility's Infection Prevention Mapping for May 2025 showed a total of 20 CAI in the facility. On 7/25/25 at 1438 hours, an interview and concurrent facility's document review was conducted with the IP. The IP stated her responsibilities included the Antibiotic Stewardship in coordination with the Infection Control Program in the facility which addressed if the antibiotic prescribed to the residents were appropriate for what were being treated, dosage, and the drug of choice for infection. When asked how she monitored the facility's Infection Control Program, the IP stated she conducted rounds daily for all shifts, provided inservices, addressed issues identified, and followed up with the staff if they were able to understand the inservices provided. The IP also stated she asked the staff questions. When asked about the purpose of the Infection Surveillance, the IP stated it was used to track and trend the infections in the facility. The IP reviewed the total number of CAI documented on the surveillance log for 4/2025 and verified there was a total of 32 CAI and not 31 as documented on the log. The IP also reviewed the total number of CAI documented on the surveillance log for 5/2025 and verified there was a total of 21 CAI and not 20 as documented on the log. The IP also verified the information presented in the Infection Prevention and Control Meeting held on 5/27 and 6/26/25, were incorrect for the total number of CAI. The IP also verified the facility's Infection Prevention Mapping for May 2025 showed incorrect total of the CAI in the facility. 2. According to AFL 18-39 dated 9/17/18, Health Care Facility Requirements include for:Hospitals, CAHs, and

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to ensure one glucometer (Glucometer A) from one of two medications carts (Medication A) inspected with the glucometers, was maintained in safe operating condition. This failure had the potential for residents requiring glucose checks to have inaccurate readings. Findings: Review of the glucometer manufacturer's manual titled Assure Platinum Blood Glucose Monitoring System User Instruction Manual under When to Perform a Control Solution Test showed:- Before testing with the Assure Platinum System glucometer for the first time- When you open a new bottle of test strips- Whenever you suspect the meter or test strips may not be functioning properly- If test results appear to be abnormally high or low or are not consistent with clinical symptoms- Use the control solution within 90 days (3 months) of first opening On 7/24/25 at 1425 hours, an inspection of Medication Cart A and concurrent interview and review of the form titled Quality Control Record Assure Platinum Blood Glucose Monitoring System was conducted with LVN 7 and the IP. One Quality Control Record showed Assure Platinum Meter Serial # 1040-4437483 for Unit 2 dated 7/2025. The last entry on the form for the Quality Control showed 7/2024. On the bottom of the page, below the entry on 7/2024, was a handwritten note showing SEE NEW PAGE NEW GLUCOMETER. Another Quality Control Record showed Assure Platinum Meter Serial # 1040-4437484 for Unit 2 dated 7/2025. The first entry on the left-hand column of the form was dated 7/25/25. No other information was documented on the form to show quality control check was conducted for the new glucometer. The IP stated the glucometer, test strips, and solution were replaced last night on all carts as a plan of correction for the concerns identified regarding Quality Control checks for the glucometer. When asked for the facility's process prior to using a new glucometer, the IP stated a Quality Control check was done when there was a new glucometer to be used. The IP also stated the night shift licensed nurse was informed to conduct a Quality Control check tonight. When asked if blood sugar checks were done today, the IP stated yes, and verified the facility used the new glucometer without performing Quality Control check prior to using the new glucometer. In addition, the Quality Control Record showed from 7/1 to 7/21/25, for the Normal Control solution, the record showed an expiration of 5/2027; however, the expiration on the solution was 2/5/27. For the High Control solution, the record showed an expiration date of 2/6/27; however, the expiration date on the solution was 2/6/27. LVN 7 verified the findings and stated she was not aware of the facility's protocols for the glucometer check. LVN 7 also stated she agreed a Quality Control check should be done when new strips were opened or for new glucometers.