STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056014	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookfield Healthcare Center	9300 Telegraph Road Downey, CA 90240

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure a complete informed consent form (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) included the medication dosage, frequency, and behavioral manifestations prior to the administration of citalopram (medication used to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest]) for one of five sampled residents (Resident 32). This deficient practice had the potential to result in Resident 32 and their Responsible Party (RP) being unaware of the medication treatment ordered, thus, being unable to make an informed decision regarding Resident 32's care. Findings: During a review of Resident 32's Admission Record (Face Sheet), indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 32's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and hypertension (elevated blood pressure). During a review of Resident 32's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 9/20/2024, the MDS indicated Resident 32's cognition (process of thinking) was moderately impaired. The MDS indicated over a two-week period Resident 32 had felt down, depressed, or hopeless for half or more of the days (seven to eleven days). The MDS indicated Resident 32 was dependent on staff for oral hygiene, toileting, showering, and bathing. The MDS indicated Resident 32 received antidepressant medication while in the facility. During a review of Resident 32's History and Physical (H&P), dated 9/17/2024, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Psychiatric Follow-Up Note, dated 9/3/2024, the Psychiatric Follow-Up Note indicated Resident 32 was diagnosed with major depressive disorder. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's Order Summary Report, order date 10/3/2024, the Order Summary Report indicated to give citalopram 10 milligrams (mg, a unit of measurement) by mouth, one time a day, for depression as manifested by anxiety (feelings of fear, dread, and uneasiness) and loss of appetite. During a review of Resident 32's Medication Administration Record (MAR), dated 10/2024, the MAR indicated Resident 32 was administered citalopram 10 mg 10/4/2024 through 10/16/2024, with the exception of 10/10/2024 and 10/13/2024 when Resident 32 had refused the medication. During an interview on 10/17/2024 at 9:45 a.m., with Registered Nurse (RN) 4, RN 4 stated when a physician orders any kind of psychotropic medication (medication that affects the mind, emotions, and behavior), they physician would have to inform the resident and/or their RP of the medication being ordered, the indication of use, and the risks and benefits. RN 4 stated the licensed nurse was then responsible for verifying with the resident and/or their RP that they were fully informed of the mediation and agree with the plan of care. RN 4 stated the licensed nurse was responsible for completing the Facility Verification of Resident Informed Consent by indicating the medication name, dosage, frequency, indication, and behavioral manifestations. RN 4 stated it was important to indicate the full medication order to ensure the correct documentation because any changes in the medication would warrant a new informed consent process to occur, such as an increase in the medication's dosage or frequency. During a concurrent interview and record review on 10/17/2024 at 9:50 a.m., with RN 4, Resident 32's Facility Verification of Informed Consent, dated 10/4/2024 was reviewed. The Facility Verification of Informed Consent indicated the proposed treatment of psychotropic medication was citalopram for depression. RN 4 stated the Facility Verification of Informed Consent was incomplete because it did not indicate the dosage, frequency, and behavioral manifestations for the use of citalopram. RN 4 stated the verifying nurse should have documented everything that was verified to ensure clear documentation that Resident 32's RP understood the medication therapy Resident 32 was to receive. RN 4 stated without the complete documentation, Resident 32 and her RP could potentially not have been fully informed of the use of citalopram to treat Resident 32's depression and could not have made a fully informed decision regarding Resident 32's care. During an interview on 10/17/2024 at 2:10 p.m., with the Director of Nursing (DON), the DON stated when the licensed nurse verified with Resident 32 and their RP regarding the use of citalopram, they were responsible for verifying they understood and agreed to the medication use, the dosage, frequency, and behavioral manifestations. The DON stated without that verification, Resident 32 and RP would be misinformed and they could be agreeing to a treatment they were not fully aware of. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medications, revised 12/2023, the P&P indicated the facility's Interdisciplinary Team ([IDT], a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) would ensure informed consent was obtained prior to medication use.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure the assessment entries on the Minimum Data Set ([MDS], a federally mandated resident assessment tool) were accurate for four of six sampled residents (Residents 3, 9, 32, and 253) when the facility failed to: 1. Include a diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) per information in Resident 32 and Resident 3's medical record. 2. Include Resident 9's five (5) percent (%) weight loss in one month. 3. Include a diagnosis of seizure disorder (a disorder where a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) per information in Resident 253's medical record. These deficient practices had the potential to negative affect Residents 3, 9, 32, and 253's plan of care and delivery of necessary care and services. Findings: a. During a review of Resident 32's Admission Record (Face Sheet), the Admission Record indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 32's diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and hypertension (elevated blood pressure). During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32's cognition (process of thinking) was moderately impaired. The MDS indicated over a two-week period Resident 32 had felt down, depressed, or hopeless for half or more of the days (seven to eleven days). The MDS indicated Resident 32 was dependent on staff for oral hygiene, toileting, showering, and bathing. The MDS indicated Resident 32 received antidepressant medication while in the facility. During a review of Resident 32's History and Physical (H&P), dated 9/17/2024, the H&P indicated Resident 32 had the capacity to understand and make decisions. During a review of Resident 32's Psychiatric Follow-Up Note, dated 9/3/2024, the Psychiatric Follow-Up Note indicated Resident 32 was diagnosed with major depressive disorder. During a review of Resident 32's Order Summary Report, order date 10/3/2024, the Order Summary Report indicated to give citalopram (an antidepressant) 10 milligrams (mg, a unit of measurement) by mouth, one time a day, for depression as manifested by anxiety (feelings of fear, dread, and uneasiness) and loss of appetite. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's Order Summary Report, order date 10/8/2024, the Order Summary Report indicated to give mirtazapine (an antidepressant) 22.5 mg, by mouth, at bedtime for depression as manifested by decreased appetite and increased verbalization of sadness. During an interview on 10/17/2024 at 8:27 a.m., with the MDS Coordinator (MDSC), the MDSC stated she was responsible for conducting the MDS assessment for the residents on admission, quarterly, and annually and to transmit in a timely manner. The MDSC stated when she conducts her assessments she would do a physical assessment with the resident, speak with the family if she needed any clarification, and review the resident's hospital records and other medical records. The MDSC stated conducting an accurate assessment for the residents would allow for the development of a patient-centered care plan to provide the care and address the needs of each resident. During a concurrent interview and record review on 10/17/2024 at 8:29 a.m., with the MDSC, Resident 32's MDS, dated [DATE] was reviewed. The MDSC stated depression was not marked as one of Resident 32's diagnoses. The MDSC stated Resident 32 had been seen by a psychologist and psychiatrist and had indicated Resident 32 had been diagnosed with depression and had been treated with antidepressants. The MDSC stated depression should have been marked on Resident 32's MDS assessment to ensure the facility provides the necessary interventions to help treat Resident 32's depression. b. During a review of Resident 3's Admission Record (Face Sheet), the Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 3's diagnoses included dementia (a progressive state of decline in mental abilities), cerebral infarction (stroke, loss of blood flow to a part of the brain), and osteoarthritis. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was severely impaired. The MDS indicated Resident 3 required setup or clean-up assistance with eating and moderate assistance (helper does less than half the effort) with toileting, dressing, and personal hygiene. The MDS indicated Resident 3 received antidepressant medication in the facility. During a review of Resident 3's H&P, dated 7/30/2024, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Psychiatric Progress Note, dated 7/19/2024, the Psychiatric Progress Note indicated Resident 3's diagnosis of major depressive disorder. During a review of Resident 3's Order Summary Report, order date 10/20/2023, the Order Summary Report indicated to give Zoloft (an antidepressant) 25 mg, via gastrostomy tube (g-tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), one time a day for depression as manifested by self-report of feeling sadness. During a concurrent interview and record review on 10/17/2024 at 8:37 a.m., with the MDSC, Resident 3's MDS, dated [DATE] was reviewed. The MDSC stated depression was not marked as one of Resident 3's diagnoses. The MDS stated Resident 3 has had long-term depression and had been taking on antidepressants for a long period of time. The MDSC stated depression should have been marked on Resident 3's MDS assessment to ensure the facility provides the necessary interventions to help treat Resident 3's depression. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. During a review of Resident 9's Admission Record (Face Sheet), the Admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 9's diagnoses included end stage renal disease ([ESRD], irreversible kidney failure), congestive heart failure ([CHF], a chronic condition in which a weakness of the heart leads to a buildup of fluid in the lungs), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 was dependent on staff for oral hygiene, toileting, bathing, dressing, and personal hygiene. During a review of Resident 9's H&P, dated 9/19/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 9's Weights and Vitals Summary, dated 7/7/2023 through 10/9/2024, the Weights and Vitals Summary indicated on 8/7/2024, Resident 9 weighed 140 pounds (lbs, unit of measurement) and on 9/4/2024, Resident 9 weighed 133 lbs. Resident 9 had a 7 lbs weight loss which was a 5 percent (%) loss. During a concurrent interview and record review on 10/17/2024 at 8:49 am., with the MDSC, Resident 9's MDS, dated [DATE], was reviewed. The MDSC stated Resident 9's MDS was marked no for weight loss of 5% or more in the last month. The MDSC stated Resident 9 had an exact 5% weight loss from 8/7/2024 to 9/4/2024 and that weight loss should have been indicated on Resident 9's MDS so they could monitor Resident 9's nutritional status and provide the appropriate interventions to prevent further weight loss. d. During a review of Resident 253's Admission Record (Face Sheet), the Admission Record indicated Resident 253 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 253's diagnoses included hydrocephalus (condition where too much fluid builds up in and around the brain and spinal cord), myoclonus (a sudden, brief involuntary twitching or jerking of a muscle or group of muscles), and encephalopathy (damage or disease of the brain that changes how the brain functions). During a review of Resident 253's MDS, dated [DATE], the MDS indicated Resident 253's cognition was severely impaired. The MDS indicated Resident 253 was dependent on staff for eating, oral hygiene, toileting, bathing, and dressing. During a review of Resident 253's H&P, dated 8/13/2024, the H&P indicated Resident 253 did not have the capacity to understand and make decisions. During a review of Resident 253's general acute care hospital (GACH) Consultation Note, dated 8/7/2024, the Consultation Note indicated Resident 253 was admitted to the GACH with a diagnosis of seizures. During a review of Resident 253's Admission Note, dated 8/9/2024, the Admission Note indicated Resident 253 was admitted to the facility with the primary diagnosis of seizures. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/17/2024 at 9 a.m., with the MDSC, Resident 253's MDS, dated [DATE] was reviewed. The MDSC stated seizure disorder was not marked as one of Resident 253's diagnoses. The MDSC stated Resident 253 was readmitted from the GACH for having seizures and seizure disorder should have been indicated on the MDS. The MDSC stated accurately indicating Resident 253's diagnosis of seizures would communicate Resident 253's medical condition to the rest of Resident 253's healthcare team to provide the necessary care. During an interview on 10/17/2024 at 2:13 p.m., with the Director of Nursing (DON), the DON stated having an accurate MDS was essential to provide the most appropriate patient centered care to each resident. The DON stated diagnoses, such as depression and seizures, and weight loss should be accurately indicated on the MDS so the facility could meet each residents' needs. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processes, revised 12/2023, the P&P indicated residents would be assessed comprehensively and accurately and would be made of the resident's needs, strengths, goals, life history and preferences and would include physical functioning, disease diagnosis, and health conditions.

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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** 45009 Based on observation, interview, and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) with interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) in a timely manner for three out of six sampled residents (Resident 153, Resident 42, and Resident 21) when the facility failed to ensure the following: 1. Ensure a care plan was developed after the discovery of Resident 153's cancer of the left eye and skin. 2. Ensure a care plan was developed for Resident 42's use of a nicotine patch (a patch worn on the skin by a person trying to give up smoking). 3. Ensure care plan interventions were developed for the care of Resident 21's ileostomy (a surgical procedure that creates an opening in the abdominal wall to divert waste from the body through the small intestine instead of the anus), and stoma (a surgically created opening in the abdomen that allows waste to exit the body into a collection bag). These deficient practices had the potential to negatively affect the provision of care for Residents 153, 42, and 21. Findings: a. During a review of Resident 153's Admission Record, indicated Resident 153 was originally admitted to the facility on [DATE] with a diagnosis of kidney failure (occurs when kidneys suddenly become unable to filter waste products from the blood, kidneys lose their filtering ability, dangerous levels of wastes may accumulate, and blood's chemical makeup may get out of balance) and congestive heart failure (heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 153's History and Physical (H&P) dated 9/12/2024, the H&P indicated Resident 153 had the capacity to understand and make decisions. During a review of Resident 153's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 9/23/2024, the MDS indicated Resident 153's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 153 required maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathing, and putting on/taking off shoes. During a review of Resident 153's Electronic Medical Record (EMR), the EMR did not have a care plan developed for Resident 153's cancer of the skin and left eye. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 8:22 a.m. with Resident 153, in Resident 153's room, Resident 153 stated she lost her vision to her left eye due to cancer. Resident 153 stated she had skin cancer and that her nurse was aware. Resident 153 stated she was told she had a dermatologist (a medical doctor who specializes in conditions that affect the skin, hair, and nails) appointment but was not sure when because staff did not inform her. Resident 153 stated the facility did not provide new treatments to her skin or asked her about her vision. Resident 153 stated she wanted to see a specialist for her skin and left eye because she wanted to get the care she needed. During an interview on 10/17/2024 at 12:49 p.m. with Registered Nurse (RN 4), RN 4 stated she was informed by Resident 153's family member (FM 1) the resident had skin cancer and needed to see a dermatologist. RN 4 stated a care plan should have been initiated for Resident 153's diagnosis of cancer but she did not initiate one. RN 4 stated it was important to develop a care plan for Resident 153's cancer diagnosis to have a proper plan of care and create goals and interventions for the resident's health. RN 4 stated if Resident 153 cancer diagnoses was not care planned there would not be any follow up of the resident's cancer and there would not be a plan of care for her diagnoses of cancer. During an interview on 10/18/2024 at 1:27 p.m. with the Director of Nursing (DON), the DON stated it was important to develop a care plan because it was the framework for a patients care. The DON stated staff developed interventions and a resident plan of care to direct care. The DON stated if something was not care planned the plan of care might not be followed. The DON stated when RN 4 was notified of Resident 153's cancer, RN 4 should have developed a care plan for continuity of care. 47679 b. During a review of Resident 42's Admission Record (Face Sheet), the admission record indicated Resident 42 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 42's diagnoses included peritonitis (redness and swelling of the lining of the abdomen), intestinal obstruction (blockage in the small or large intestine that prevents food, liquid, gas, and stool from passing though normally), and acute embolism and thrombosis of the deep veins of the lower extremity (a blood clot that forms in a vein deep in the body). During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognition was intact. The MDS indicated Resident 42 required setup or clean-up assistance with eating and oral and personal hygiene. The MDS indicated Resident 42 required supervision with toileting and upper and lower dressing. During a review of Resident 42's Physician Admission Progress Note, dated 4/8/2024, the Progress Note indicated Resident 42 was alert (actively aware of the world, anticipating actions, and responding appropriately). During a review of Resident 42's Order Recap Report, dated 5/1/2024 through 10/31/2024, the Order Recap Report indicated: 1. Apply one nicotine patch 14 milligrams (mg, unit of measurement) per 24 hours (14 mg/24hr), transdermally (on the skin), one time a day for smoking cessation (process of stopping smoking tobacco) for six weeks and remove per schedule. Order date was 5/21/2024 and the duration of therapy was 5/22/2024 through 7/3/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Apply one nicotine patch 7 mg/24 hr, transdermally, one time a day for smoking cessation for two weeks and remove per schedule. Order date was 5/21/2024 and the duration of therapy was 7/3/2024 through 7/17/2024. 3. Apply one nicotine patch 21 mg/24 hr, transdermally, one time a day for smoking cessation and remove per schedule. Order date was 8/9/2024 and the duration of therapy was 8/10/2024 through 8/13/2024. 4. Apply one nicotine patch 21 mg/24 hr, transdermally, one time a day for smoking cessation and remove per schedule. Order date was 8/13/2024 and the duration of therapy was 8/14/2024 through 9/21/2024. 5. Apply one nicotine patch 14 mg/24 hr, transdermally, one time a day for smoking cessation for two weeks and remove per schedule. Order date was 8/13/2024 and the duration of therapy was 9/21/2024 through 10/5/2024. 6. Apply one nicotine patch 7 mg/24 hr, transdermally, one time a day for smoking cessation for two weeks and remove per schedule. Order date was 8/13/2024 and the duration of therapy was 10/5/2024 through 10/16/2024. During an interview on 10/17/2024 at 8:12 a.m., with the MDS Coordinator (MDSC), the MDSC stated her role was to assess the residents upon admission and quarterly to complete the MDS and to develop patient-centered care plans. The MDSC stated care plans were used as a tool that would guide the staff to provide the necessary care to the residents. The MDSC stated care plans were developed based on the resident's assessment, medical diagnoses, and medications. The MDSC stated she based the planning and interventions on the resident's conditions and ensure the care plans were patient-centered to reach a goal. The MDSC stated care plans were developed for medications to ensure proper monitoring for any side effects and to evaluate if the medication was effective. The MDSC stated care plans should be developed as soon as possible so they could monitor the effectivity of the medication and the potential side effects. During a concurrent interview and record review on 10/17/2024 at 8:15 a.m., with the MDSC, Resident 42's Care Plan titled, Resident on nicotine patch for smoking cessation, initiated on 10/16/2024, was reviewed. The Care Plan indicated a goal for Resident 42 would refrain from smoking and interventions of the staff to ask resident about his tobacco use and to assess the resident's motivation to participate and continue with the smoking cessation plan. The MDSC stated she had initiated this care plan on 10/16/2024 because Resident 42 was seen that day in the smoking patio smoking a cigarette. The MDSC stated Resident 42 has had the nicotine patch applied on him daily starting in May 2024. The MDSC stated Resident 42's care plan for the use of the nicotine patch should have been developed at that time to help Resident 42 continue with his smoking cessation plan. The MDSC stated if the care plan had been developed earlier and the interventions had been implemented, the staff could have monitored Resident 42's desire to smoke closer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 2:15 p.m., with the DON, the DON stated Resident 42's care plan that addressed Resident 42's use of a nicotine patch should have been developed when it was initially ordered in May 2024. The DON stated Resident 42 wanted to stop smoking and was placed on the nicotine patch in hope he would not smoke again. The DON stated Resident 42 had smoked on 10/15/2024 for the first time and if Resident 42's care plan was developed and implemented earlier, that could have possibly prevented Resident 42 from smoking again. 47858 c. During a review of Resident 21's Admission Record, the admission record indicated Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 21's diagnoses included infection of the ileostomy surgical site and acute kidney failure. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21's cognition was intact. The MDS indicated Resident 21 was dependent on staff for toileting and showering, required supervision when eating, and required maximal assistance when dressing. During a review of Resident 21's Physician Orders, dated 9/23/2024, the Physician Orders indicated to change Resident 21's [ileostomy] bag (a bag connected to Resident 21's ileostomy to collect waste) when the bag was one-fourth or one-half full. The orders also indicated to wash [the ileostomy] with soap and water every shift and as needed. During a review of Resident 21's Care Plans dated 9/2024 to 10/2024, it was indicated there were no care plans initiated that identified specific interventions for the care and monitoring of Resident 21's stoma (a surgically created opening in the abdomen that allows waste to exit the body into a collection bag) or ileostomy bag. During a concurrent interview and record review, on 10/18/2024, at 8:44 a.m., with RN 2, all of Resident 21's care plans were reviewed. RN 2 stated there were no care plans specific to the care and assessment of Resident 21's ileostomy. RN 2 stated that care plans were important to be developed to guide the care of residents. RN 2 stated the care for Resident 21's ileostomy included monitoring and checking the stoma for any bleeding or infection, changing the bag, and cleaning the stoma and surrounding skin daily. RN 2 stated that without a care plan, there would not be a guide for the nurses to follow when care was provided for Resident 21's ileostomy and stoma. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, the P&P indicated, The interdisciplinary team ([IDT], a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on interview and record review, the licensed nurses failed to review, update, and/or revise a care plan (written document developed for each individual by the support team using a person-centered approach that describes the supports, services, and resources provided or accessed to address the needs of the individual) to reflect the attempts to prevent future falls for one out of one sampled resident (Resident 21). This deficient practice resulted in the facility having no interventions in the prevention for further falls for Resident 21 and could have potentially led to Resident 21's third fall. Findings: During a review of Resident 21's Admission Record, the admission record indicated Resident 21 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 21's diagnoses included history of falls and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). During a review of Resident 21's History and Physical (H&P) dated 9/30/2024, the H&P indicated Resident 21 was alert and had appropriate mood, affect and insight. During a review of Resident 21's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/2/2024, the MDS indicatedResident 21's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 21 required moderate assistance (helper does less than half the effort) for toileting hygiene, upper body dressing and personal hygiene. During a review Resident 21's Care Plan dated 8/19/2021, the care plan indicated Resident 21 was at risk for falls due to generalized weakness, poor cognition, and history of falls. The care plan indicated Resident 21's goal was to minimize the risk of injuries and not to sustain a serious injury due to a fall. The staff's interventions indicated to anticipate Resident 21's needs, place the call light within reach and encourage the resident to use it, maintain Resident 21's bed in the lowest position, and encourage the resident to wear appropriate footwear when ambulating (walking) or wheeling in a wheelchair. The care plan indicated no revisions were made after Resident 21 had a fall on 8/9/2024 and 9/16/2024. During a review of Resident 21's Situation Background Assessment Recommendation (SBAR) Communication form, dated 8/9/2024 9/16/2024 and 10/4/2024, the SBAR indicated Resident 21 had a fall on 8/9/2024 9/16/2024 and 10/4/2024. During an interview on 10/17/2024 at 2:45 p.m. with Registered Nurse (RN 3), RN 3 stated after a resident has a fall their clan plan must be revised. RN 3 stated it was important to revise care plans to offer guidance in preventing future falls. RN 3 stated if a care plan was not revised it would delay treatment and the resident could fall again. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 1:27 p.m. with the Director of Nursing (DON), the DON stated a care plan was an outline for a resident's care. The DON stated it was important to have care plans because it was a resident's framework to their care. The DON stated after Resident 21's falls the care plan should have been revised. The DON stated care plan revisions introduced new interventions to prevent further falls. During a review of the facility's Policy and Procedure (P&P) titled ,Fall Management System dated 12/2023, the P&P indicated it was the facility's policy to provide an environment that remains as free of accidents hazards as possible. The P&P indicated the facility would provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The P&P indicated the care plan must be updated after every fall.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review the facility failed to ensure an interdisciplinary team (IDT, group of different disciplines working together towards a common goal of a resident) meeting was held after a resident fall on 9/16/2024 for one of one sampled resident (Resident 21). This deficient practice delayed the plan of care for reducing the risk of falls and could potentially have caused Resident 21 to sustain another subsequent fall. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 21's diagnoses included history of falls and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). During a review of Resident 21's History and Physical (H&P) dated 9/30/2024, the H&P indicated Resident 21 was alert and had appropriate mood, affect and insight. During a review of Resident 21's Minimum Data Set (MDS, a federally mandated assessment tool), dated 8/2/2024, the MDS indicated Resident 21's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 21 required moderate assistance (helper does less than half the effort) for toileting hygiene, upper body dressing and personal hygiene. During a review of Resident 21's Situation Background Assessment Recommendation (SBAR) Communication forms, dated 8/9/2024, 9/16/2024, and 10/4/2024, the SBARs indicated Resident 21 had falls on 8/9/2024, 9/16/2024, and 10/4/2024 . During a review of Resident 21's IDT notes, dated 8/9/2024 and 10/4/2024, the IDT notes indicated Resident 21 had a fall on those two dates. During a review of Resident 21's electronic medical record (EMR), the EMR indicated there were no IDT notes for Resident 21's fall on 9/16/2024. During an interview on 10/17/2024 at 1:10 p.m. with Registered Nurse (RN 4), RN 4 stated after every fall there must be an IDT meeting to plan the care for a resident. RN 4 stated a fall was a change of condition which should be documented and an IDT meeting done. RN 4 stated during an IDT meeting, staff develop a plan to prevent future falls. RN 4 stated if there was no IDT meeting done after a fall, there would be no interventions to follow and the resident could potentially fall again. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 1:27 p.m. with the Director of Nursing (DON), the DON stated an IDT meeting was held after a resident had a fall to have a collaborated talk about the plan of care for the resident. The DON stated if an IDT was not done, fall interventions could be delayed and could potentially lead to another fall. The DON stated Resident 21 had a high risk for falls and an IDT meeting could develop interventions to reduce the risk for injury. The DON stated a fall was a change of condition and all change of conditions resulted in an IDT meeting. The DON stated Resident 21 should have had an IDT meeting after the resident's fall on 9/16/2024. During a review of the facility's Policy and Procedure (P&P) titled Significant change of conditions dated 12/2023, the P&P indicated when a fall or other related incidents occurred, the IDT shall collaborate with the attending physician, resident, and/or resident representatives to review risk indicators and the plan of care. The P&P indicated the IDT will document this collaboration in the EMR.

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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** 47679 Based on observation, interview, and record review, the facility failed to ensure two of 12 sampled residents (Residents 253 and 21) were free of accidents and hazards by failing to: 1. Ensure floor mats (a cushioned floor pad designed to help prevent injury should a person fall) were utilized for Resident 253. 2. Ensure Resident 21 had an interdisciplinary team ([IDT], a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) review after a fall on 9/16/2024. These deficient practices had the potential to result in Resident 253 sustaining injuries during a seizure (a disorder in which nerve cell activity in the brain is disturbed) by potentially falling and hitting his head or other body parts on the bare floor. These deficient practices also resulted a delay in the plan of care for reducing the risk of falls and could have potentially caused Resident 21 to fall for a third time. Findings: a. During a review of Resident 253's Admission Record (Face Sheet), the Admission Record indicated Resident 253 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 253's diagnoses included hydrocephalus (condition where too much fluid builds up in and around the brain and spinal cord), myoclonus (a sudden, brief involuntary twitching or jerking of a muscle or group of muscles), and encephalopathy (damage or disease of the brain that changes how the brain functions). During a review of Resident 253's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 8/12/2024, the MDS indicated Resident 253's cognition (process of thinking) was severely impaired. The MDS indicated Resident 253 was dependent on staff for eating, oral hygiene, toileting, bathing, and dressing. During a review of Resident 253's History and Physical (H&P), dated 8/13/2024, the H&P indicated Resident 253 did not have the capacity to understand and make decisions. During a review of Resident 253's Order Summary Report, dated 8/12/2024, the Order Summary Report indicated to place the floor mat adjacent (close or near) to the bed for safety and seizure precautions. During a review of Resident 253's Care Plan, dated 8/14/2024, the Care Plan indicated Resident 253 had the potential for injury and the potential for episodes of seizure activity. The staff's interventions indicated was to place the floor mat adjacent to the bed for safety and seizure precautions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/15/2024 at 10:01 a.m. and 10/16/2024 at 9:02 a.m., in Resident 253's room, Resident 253 was observed lying in bed. One floor mat was observed on the right side of Resident 253's bed. No floor mat on the left side of Resident 253's bed was observed. During a concurrent observation and interview on 10/15/2024 at 2:30 p.m., with Licensed Vocational Nurse (LVN) 1, in Resident 253's room, Resident 253 was observed lying in bed and only one floor mat was observed on the right side of Resident 253's bed. LVN 1 stated Resident 253 only had a floor mat on the right side of his bed and did not have a floor mat on the left side of his bed. LVN 1 stated Resident 253's physician ordered a floor mat adjacent to Resident 253's bed for safety in the event Resident 253 had a seizure. LVN 1 stated if Resident 253 had a seizure, the resident potentially could move to his left or his right and could fall to the floor. LVN 1 stated there should have been a floor mat on both sides of Resident 253's bed because he could have a fall and have a serious injury such as a fracture (broken bone) or a head injury. During an interview on 10/17/2024 at 2:20 p.m., with the Director of Nursing (DON), the DON stated floor mats were utilized for Resident 253 as a seizure precaution. The DON stated Resident 253 should have had bilateral (both sides) floor mats. The DON stated Resident 253 was at risk for injury if he were to have a seizure and if he did not have bilateral floor mats, Resident 253 could fall to the ground and hit his head or sustain other injuries ranging from minor to major. During a review of the facility's policy and procedure (P&P) titled, Fall Management System, revised 12/2023, the P&P indicated the facility was to provide an environment that remains as free of accidents hazards as possible and to provide each resident with appropriate interventions to prevent falls and minimize complications. 45009 b. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 21's diagnoses included history of falls and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). During a review of Resident 21's History and Physical (H&P) dated 9/30/2024, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 21 required moderate assistance (helper does less than half the effort) for toileting hygiene, upper body dressing and personal hygiene. During a review of Resident 21's Situation Background Assessment Recommendation (SBAR) Communication form, dated 8/9/2024 9/16/2024 and 10/4/2024, the SBARs indicated Resident 21 had a fall. During a review of Resident 21's IDT notes, dated 8/9/2024 and 10/4/2024, the IDT notes indicated Resident 21 had a fall on 8/9/2024 and 10/4/2024. During a review of Resident 21's electronic medical record (EMR), the EMR indicated there were no IDT notes for Resident 21's fall on 9/16/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 1:10 p.m. with Registered Nurse (RN 4), RN 4 stated after every fall there must be an IDT meeting to plan the care for a resident. RN 4 stated a fall was a change of condition and should be documented and an IDT meeting should be done. RN 4 stated during an IDT meeting staff should develop a plan to prevent future falls. RN 4 stated if there was no IDT meeting done after a fall, there would be no interventions to follow and the resident could potentially fall again. During an interview on 10/18/2024 at 1:27 p.m. with the DON, the DON stated an IDT meeting was held after a resident had a fall to have a collaborated talk about plan of care for the resident. The DON stated if an IDT was not done, fall interventions could be delayed and could potentially lead to another fall. The DON stated Resident 21 was a high risk for falls and an IDT meeting could develop interventions to reduce the risk for injury. The DON stated a fall was a change of condition and all change of conditions resulted in an IDT meeting. The DON stated Resident 21 should have had an IDT meeting after his fall on 9/16/2024. During a review of the facility's P&P titled Significant change of conditions dated 12/2023, the P&P indicated when a fall or other related incidents occurred, the IDT shall collaborate with the attending physician, resident, and/or resident representatives to review risk indicators and the plan of care. The P&P indicated the IDT will document this collaboration in the EMR.

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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** 45009 31333 Based on observation, interview, and record review, the facility failed to ensure licensed nursing staff practiced safe and effective medication administration practices for four out of five sampled residents (Resident 19, 25, 48, and 49) when: 1. Registered Nurse (RN 2) did not administer medication to Resident 19 in a timely manner. 2. RN 3 left Resident 25's medications at the resident's bedside to self-administer. 3. Licensed Vocational Nurse (LVN) 2 did not administer medication to Resident 25 in a timely manner. 4. LVN 2 did not administer medication to Resident 48 in a timely manner. 5. LVN 1 signed the medication administration audit report for Resident 49 after another LVN administered pain medication. These deficient practices caused Resident 19, 25, 48, and 49 to have an interruption with their medication therapy and exposed the residents to a potential medication error and adverse effect to their medications. Findings: 1. During an observation on 10/17/2024 at 10:15 a.m., in Resident 19's room, Resident 19 was observed with a medicine cup containing five pills at her bedside. During a review of Resident 19's Admission Record, the Admission Record indicated Resident 19 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 19's diagnoses included diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension ([HTN] high blood pressure). During a review of Resident 19's History and Physical (H&P) dated 9/30/2024, the H&P indicated Resident 19 was able to make her own decisions and was alert and oriented. During a review of Resident 19's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated Resident 19's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 19 required maximal assistance (helper does more than half the effort) for oral hygiene, upper body dressing and personal hygiene. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 19's Medication Administration Audit Report dated 10/16/2024, the report indicated Resident 19 had an order to receive medications at 9:00 a.m. The report indicated Resident 19 received the following medications on 10/16/2024 at 11:36 a.m.: 1. Pro-Stat oral liquid, 30 milliliters by mouth, for supplement. 2. Enulose solution 10/15ml, 30 ml by mouth one time a day for bowel management. 3. Miralax oral powder 17gm/scoop, 1 scoop by mouth one time a day for bowel management. 4. Docusate sodium oral tablet 100 mg, 1 tablet by mouth two times a day for bowel management. 5. Oxybutynin chloride 5 mg, 1 tablet by mouth one time a day for overactive bladder. 6. Metformin 1000mg, give 1 tablet by mouth two times a day for DM. 7. Valsartan-hydrochlorothiazide tablet 320-12.5 mg, give 1 tablet by mouth one time a day for HTN. 8. Hydralazine 50 mg, give 1 tablet by mouth two times a day for HTN. 9. Jardiance 10 mg, give 1 tablet by mouth one time a day for DM. 10. Doxazosin mesylate 2 mg, give 1 tablet by mouth one time a day for HTN. 11. Aspirin 81 mg, give 1 tablet by mouth two times a day for deep vein thrombosis ([DVT] a condition where a blood clot forms in a large vein deep within the body). During an interview on 10/16/2024 at 10:55 a.m. with Resident 19, Resident 19 stated she was worried that she had not received her medications for that day (10/16/2024). Resident 19 stated she was worried she had not received her medication for her blood pressure and blood sugar. Resident 19 stated she had not seen her nurse yet. During an interview on 10/16/2024 at 11:15 a.m. with Registered Nurse (RN) 2, RN 2 stated he had not given Resident 19 medication yet because Resident 19 was in therapy and he (RN 2) was running a little behind on medication pass. RN 2 stated he was supposed to give Resident 19 her medications at 9:00 a.m. RN 2 stated he would give Resident 19 her medication after he was finished with his current task. During an interview on 10/17/2024 at 8:15 a.m. with Resident 19, Resident 19 stated RN 2 came to her room to give her the morning medications. Resident 19 stated she had not taken the medication yet because she was eating. Resident 19 stated RN 2 gave her a medicine cup that contained her medication and asked her to self-administer the medications when she was done eating. Resident 19 stated she had five pills in the medicine cup, two pills were for her blood pressure, one pill was for her blood sugar and she did not know wat the other two were. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility on [DATE]. Resident 25's diagnoses included diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should. Heart failure can occur if the heart cannot pump [systolic] or fill [diastolic] adequately). During a review of Resident 25's H&P dated 10/7/2024, the H&P indicated Resident 25 had good judgement and insight and was alert and oriented to person, place, time, and event. During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 25 needed maximal assistance (helper does more than half the effort) for oral hygiene. The MDS indicated Resident 25 was dependent on staff for toileting hygiene, dressing, and shower/bathing. During a review of Resident 25's Medication Administration Audit Report dated 10/17/2024, the report indicated Resident 25 had an order to receive medications at 8:00 a.m. The report indicated the following medications were administered at on 10/17/2024 at 11:44 a.m.: 1. Ferrous Sulfate 325mg tablet,1 tablet by mouth three times a day for supplement. 2. Dextromethorphan oral syrup10-100mg/5ml, 5 ml by mouth every 4 hours for cough. 3. Calcium 250 mg, 2 tablets by mouth every 12 hours for supplement. 4. Lasix 40 mg oral tablet, 1 tablet by mouth one time a day for bilateral lower extremities edema (swelling). 5. [NAME]-Vite tablet, 1 tablet by mouth one time a day for supplement. 6. Cyanocobalamin tablet 100 micrograms ([mcg] metric unit of measurement, used for medication dosage and/or a mount), 1 tablet by mouth one time a day for supplement. 7. Docusate Sodium tablet 100mg, 1 tablet by mouth one time a day for bowel management. 8. Farxiga oral tablet 5 mg, 1 tablet by mouth one time a day for DM. During an interview on 10/17/2024 at 10:18 a.m. with Resident 25, Resident 25 stated she did not remember receiving her medications that day (10/17/2024). Resident 25 stated it was important for her to receive her medication on time to prevent getting sicker. During an interview on 10/17/2024 at 1058 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she had not given Resident 25's 9:00 a.m. medication because she was running late and got sidetracked. LVN 2 stated it was not acceptable to administer medications to residents two hours late because the residents need their medications. LVN 2 stated she was running late with her medication pass because she was new. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 2:21 p.m. with RN 3, RN 3 stated it was acceptable to administer a medication 1 hour before the scheduled time and 1 hour after the scheduled time. RN 3 stated she provided a medicine cup with medications to Resident 25 to take after the resident finished eating. RN 3 stated it was not an acceptable practice to let Resident 25 self-administer medications because there was no way of knowing if the resident took the medications or if resident had a reaction to the medication. RN 3 stated she documented she administered medications to Resident 25 at on 10/16/2024 at 8:09 a.m., but she handed the medications to Resident 25 and did not know if Resident 25 took the medication. RN 3 stated it was not acceptable to document she administered the medication because she did not see Resident 25 take the medication. 3. During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 48's diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your own, lungs can't get enough oxygen into the blood) and kidney failure (occurs when kidneys suddenly become unable to filter waste products from the blood, kidneys lose their filtering ability). During a review of Resident 48's H&P dated 9/30/2024, the H&P indicated Resident 48 had fluctuating capacity to understand and make decisions. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognitive skills for daily decision making was intact. The MDS indicated Resident 48 required set up assistance for eating and oral hygiene. The MDS indicated Resident 48 was dependent on staff for toileting hygiene, dressing, and putting on/taking off shoes. During a review of Resident 48's Medication Administration Audit Report dated 10/17/2024, the report indicated Resident 48 had an order to receive medications at 9:00 a.m. The report indicated the following medications were administered on 10/17/2024 at 11:50 a.m.: 1. Cozaar oral tablet, 25 mg by mouth one time day for HTN. 2. Citalopram hydrobromide oral tablet 20 mg, 1 tablet by mouth one time a day for depression (feelings of sadness). 3. Carvedilol oral tablet 6.25 mg, 1 tablet by mouth two times a day for HTN. 4. Pro Stat oral liquid, 30 ml by mouth one time a day for skin management/wound healing. 5. Ferrous Sulfate tablet 325 mg, 1 tablet by mouth one time a day for supplement. 6. Zinc Sulfate capsule 220 mg, 1 capsule by mouth one time a day for skin management/wound healing. 7. LidoRx external gel 1%, apply to affected area topically three times a day for pain management. 8. Gabapentin oral capsule 30 mg, 1 capsule by mouth 3 times a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). 9. Ascorbic acid tablet 500 mg, 1 tablet by mouth one time a day for skin management/wound healing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 10:28 a.m. with Resident 48, Resident 48 stated she had not received her morning medications. Resident 48 stated the nurses sometimes ran late giving her the medications. Resident 48 stated she knew the nurses sometimes got busy but it was important for her to get her medications. During an interview on 10/17/2024 at 1058 a.m. with LVN 2, LVN 2 stated she had not given Resident 48's 9:00 a.m. medication because she was running late and got sidetracked. LVN 2 stated it was not acceptable to administer medications to residents two hours late because the residents need their medications. LVN 2 stated she was running late with her medication pass because she was new. 4. During a review of Resident 49's Admission Record, the Admission Record indicated Resident 49 was admitted to the facility on [DATE]. Resident 49's diagnoses included diabetes mellitus and hypertension. During a review of Resident 49's H&P dated 9/24/2024, the H&P indicated Resident 49 was alert and oriented to person, place, time, and event. During a review of Resident 49's MDS, dated [DATE], the MDS indicated that Resident 49's cognitive skills for daily decision making was intact. The MDS indicated Resident 49 required maximal assistance for toileting hygiene, shower/bathing, lower body dressing and personal hygiene. During a review of Resident 49's Medication Administration Audit Report dated 10/15/2024, the report indicated Resident 49 had an order to receive oxycodone - acetaminophen (medication used to treat moderate to severe pain) oral tablet 325 mg, 1 tablet by mouth every 12 hours as needed for severe pain. The audit report indicated LVN 1 administered the medication to Resident 49. During an interview on 10/15/2024 at 12:22 p.m. with Resident 49, Resident 49 stated she was given her routine morning medications by a female nurse. Resident 49 stated she was confused when a male nurse came to give her pain medication and no one told her why the nurses were changed. Resident 49 stated she thought it was weird to send another nurse to give her pain medication. During a concurrent interview and record review on 10/15/2024 at 1:02 p.m. with LVN 1, Resident 49's Medication Administration Audit Report dated 10/15/2024 was reviewed. The audit report indicated LVN 1 administered oxycodone -acetaminophen 325 mg for pain control to Resident 49 at 10:57 a.m. LVN 1 stated Resident 49 received the pain medication when the resident requested it. LVN 1 stated she documented she administered the pain medication to Resident 49 but it was another nurse that actually gave it to the resident. LVN 1 stated she was not supposed to document she administered a medication when she did not do it because it was not a safe practice. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 1:27 p.m. with the Director of Nursing (DON), the DON stated it was not acceptable for a nurse to leave medications at a resident's bedside for them to self-administer because the resident might not take medication. The DON stated it was important to give residents their medication at the scheduled time to avoid taking it close to their next dose of the same medication. The DON stated a nurse should not document that they administered a medication to a resident when they did not. The DON stated it was not an acceptable practice because the nurse could not confirm the resident actually received the medication. The DON stated the acceptable time for a resident to wait for their medication was one hour after their scheduled time. The DON stated if a resident did not receive their blood pressure medication on time, the resident's blood pressure would rise and it would not be controlled. The DON stated any late medication would not help the residents' health. The DON stated it was important for residents to receive their medications on time to avoid any negative effects from not getting the medications at their scheduled time. During a review of the facility's Policy and Procedure (P&P) titled, Administration Procedures for all Medications dated 6/2021, the P&P indicated it was the facility's policy to administer medications in a safe and effective matter. The P&P indicated after licensed nurse administered medication, the licensed nurse must document medication administration. The P&P indicated the licensed nurse should monitor for side effects or adverse drug reactions immediately after administration. During a review of facility's P&P titled, Medication Administration-General Guidelines dated 11/2021, the P&P indicated the facility had sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. The P&P indicated medications were to be administered within 60 minutes of the scheduled time. The P&P indicated the individual who administers the medication dose records the administration on the resident's medication administration record after the medication pass is complete.

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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** 31333 Based on interview and record review, the facility failed to identify a drug irregularity (any deviation in the proper use, dosage, or administration of medication) during the Monthly Regimen Review (MRR - a regular assessment of a resident's medication and treatment plan every month to ensure it is effective, safe, and still necessary) for one of three residents (Resident 30) receiving duplicate drug therapy in the use of two orally inhaled medications, Serevent Diskus (salmeterol, a long-acting bronchodilator used to treat asthma by relaxing and opening air passages in the lungs, making it easier to breathe) and Advair Diskus (a medication that contains both salmeterol and fluticasone propionate, an anti-inflammatory medicine, used to treat asthma and chronic obstructive pulmonary disease (COPD - lung disease that makes it difficult to breathe) between 9/13/2024 through 10/15/2024. (Cross Reference F757) This deficient practice created the risk for Resident 30 to receive excessive dosages of salmeterol which are contained in both Advair and Serevent which could lead to the resident experiencing serious side effects that include, high blood pressure, fast heart rate, irregular heart rhythm, which could result in an overdosage or hospitalization . Findings: During a review of Resident 30's Admission Record (document containing diagnostic and demographic information), the Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included asthma (chronic inflammatory disease of the lungs) and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/17/2024, the MDS indicated Resident 30 had intact cognition (ability to understand and process information). During a review of Resident 30's physician order indicated, the physician order indicated the resident was prescribed: 1. Advair Diskus (fluticasone and salmeterol) 250 micrograms ([mcg] - unit of measure of weight)/ 50 mcg, instructions indicated, one inhalation by mouth every 12 hours for COPD (Rinse mouth with water after use), order date 9/13/2024. 2. Serevent Diskus (salmeterol) 50 mcg, instructions indicated, one inhalation by mouth every 12 hours for COPD, order date 9/13/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review Resident 30's MRR form titled, Clinically Significant Medication Regimen Review Communication Form, date 9/13/2024, the MRR form indicated, A drug regimen review was conducted to identify potential clinically significant medication issues, Upon completion of this review the following has been identified for your patient, a boxed was marked to indicated, No issues found during the drug regimen review. The spaces for Drug-Drug Interactions and Drug Duplications were both left blank, unmarked. During an interview on 10/17/2024 at 1:11 PM, in the presence of the Director of Nursing (DON), with the facility's Consultant Pharmacist (Pharm 1) via telephone, Pharm 1 stated, he had not reviewed Resident 30's medications. Pharm 1 stated had he seen the two medications (Advair and Serevent) he would have written a note to ask Resident 30's doctor if the doctor wanted the resident to be on both medications. Pharm 1 stated side effects of using both medications may include tachycardia (a fast heart rate), heart palpitations (fast or irregular heartbeat) or jitteriness (feeling of nervousness or shakiness). Pharm 1 stated his job included pointing out to the physician the overuse of salmeterol and medications that may cause increased risk of harm to the residents. During an interview on 10/17/2024 at 1:36 PM, in the presence of the DON, with the facility's dispensing Pharmacist (Pharm 2) via telephone, Pharm 2 reviewed Resident 30's medication orders and stated, that it did look like Serevent had salmeterol and Advair also have salmeterol and both medications were taken by the resident twice daily and that would be a duplicate therapy. Pharm 2 stated the duplicate therapy should have alerted when the dispensing pharmacist reviewed the orders for Serevent and Advair. Pharm 2 stated there was no documentation that Resident 30's doctor was called to clarify the order. Pharm 2 stated if there are any drug interactions it should be documented on the drug (medication) regimen review (MRR) when the resident was admitted to the facility. Pharm 2 stated that giving Advair and Serevent together with both having salmeterol as the active ingredient were considered drug duplication and the resident (Resident 30) could experience increase in side effects that include chest pain or chest palpitations. During a review of the facility's policy and procedure (P&P) titled, Medication (Drug) Regimen Review (MRR), dated 12/2023, the P&P indicated, A medication regimen review (MRR) includes a review of the resident's medical chart. Identified irregularities will be documented on a separate written report that includes the resident's name, the relevant drug, and the irregularity identified. The report will be sent to the attending physician, the facility's Medical Director, and the Director of Nursing Services (DNS) to be acted upon .The MRR includes identification of irregularities, medication-related errors, adverse consequences, and use of unnecessary drugs. Unnecessary drug is defined as medications ordered: 1. In excessive dosage (including duplicate drug therapy); or 2. For excessive duration; or 3. Without adequate monitoring; or 4. Without adequate indications for its use; or 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47858

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interview and record review, the facility failed to ensure one of three sampled residents (Residents 30) would not be administered any unnecessary medication in the form of duplicate drug therapy. (Cross Reference F756) The deficient practice created the risk for Resident 30 to receive excessive dosages of salmeterol (long-acting bcta2-adrcnergic agonist [[NAME]] medication, used to treat asthma - chronic inflammatory disease of the lungs) which are contained in both oral inhalers, Serevent Diskus (salmeterol) and Advair Diskus (a medication that contains both salmeterol and fluticasone propionate, an anti-inflammatory medicine, used to treat asthma and chronic obstructive pulmonary disease (COPD - lung disease that makes it difficult to breathe) which could lead to the resident experiencing serious side effects that include, high blood pressure, fast heart rate, irregular heart rhythm, which could result in an overdosage or hospitalization . Findings: During a review of Resident 30's Admission Record (document containing diagnostic and demographic information), the Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included asthma and COPD. During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/17/2024, the MDS indicated Resident 30 had intact cognition (ability to understand and process information). During a review of Resident 30's physician order, the physician order indicated the resident was prescribed: 1. Advair Diskus (fluticasone and salmeterol) 250 micrograms ([mcg] - unit of measure of weight)/ 50 mcg, instructions indicated, one inhalation by mouth every 12 hours for COPD (Rinse mouth with water after use), order date 9/13/2024. 2. Serevent Diskus (salmeterol) 50 mcg, instructions indicated, one inhalation by mouth every 12 hours for COPD, order date 9/13/2024. During a review of Resident 30's Medication Administration Records (MAR - a document that tracks medications given to a resident, including dosages, times, and the person administering them to ensure accurate and safe administration) for the months of 9/2024 and 10/2024. Resident 30's 9/2024 and 10/2024 MARs indicated the resident was administered both Advair and Serevent daily from 9/13/2024 through 10/15/2024. During a clinical record review on 10/16/2024 at 2:41 PM, Resident 30's physician orders and MARs between 9/13/2024 through 10/15/2024 were reviewed. Resident 30's MAR documentation, indicated by licensed nurses' initials that Resident 30 was administered both Advair and Serevent together for a total of 65 doses of Advair and 64 doses of Serevent for 33 days from 9/13/2024 through 10/15/2024. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 11/17/2024 at 11:02 AM, with Registered Nurse (RN) 3, Resident 30's MARS for 9/2024 and 10/2024 were reviewed. RN 3 stated the initials on 9/20/2024 at 9 AM belonged to RN 3. RN 3 stated Resident 30 was administered Advair and Serevent inhalers at the same time. RN 3 acknowledged that Advair inhaler and Serevent inhaler both contain the same active ingredient salmeterol. RN 3 stated, I thought because they (Advair and Serevent) were scheduled at the same time that it was okay to give at the same time. RN 3 stated that she did not ask another nurse, a supervisor, call a pharmacist or use any drug reference to determine if the two inhalers, Advair and Serevent were okay to be administered together to Resident 30. During a concurrent interview and record review on 11/17/2024 at 11:22 AM, with Licensed Vocational Nurse (LVN) 2, Resident 30's MARs for 9/2024 and 10/2024 were reviewed. LVN 2 stated that she administered both inhalers, Advair and Serevent together to Resident 30 on 10/2/2024 and 10/4/2024, but did not recall which inhaler was administered first. During an interview on 10/17/2024 at 11:38 AM, with the Director of Nursing (DON), the DON stated once the surveyor identified there was no open date (the date the medication was first opened) on Resident 30's opened inhalers of Advair and Serevent, that was when the DON saw that the two inhalers contained the same active ingredient salmeterol. The DON stated she reached out to the pharmacist and the pharmacist informed her that one of the medications should be discontinued. The DON stated the facility's pharmacist missed the duplication in drug therapy when the Monthly Regimen Review (MRR - a regular assessment of a resident's medication and treatment plan every month to ensure it is effective, safe, and still necessary) was reviewed on 9/13/2024. The DON read the manufacturer's labeling for Serevent that indicated a warning of an increased risk for overdose when an active ingredient salmeterol was given together with another medication containing the same active ingredient. During an interview on 10/17/2024 at 1:11 PM, in the presence of the DON, with the facility's Consultant Pharmacist (Pharm 1) via telephone, Pharm 1 stated, he had not reviewed Resident 30's medications. Pharm 1 stated side effects of using both medications may include tachycardia (a fast heart rate), heart palpitations (fast or irregular heartbeat) or jitteriness (feeling of nervousness or shakiness). Pharm 1 stated his job included pointing out to the physician the overuse of salmeterol and medications that may cause increased risk of harm to the residents. During an interview on 10/17/2024 at 1:36 PM, in the presence of the DON, with the facility's dispensing pharmacist (Pharm 2) via telephone, Pharm 2 stated that giving Advair and Serevent together with both having salmeterol as the active ingredient was considered drug duplication and the resident (Resident 30) could experience an increase in side effects that include chest pain or chest palpitations. During a review of the facility's policy and procedure (P&P) titled, Administration Procedures for All Medications, dated 6/2021, the P&P indicated, To administer medications in a safe and effective manner .If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information . During a review of the facility's P&P titled, Medication (Drug) Regimen Review (MRR), dated 12/2023, the P&P indicated, Unnecessary drug is defined as medications ordered: o In excessive dosage (including duplicate drug therapy); or (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o For excessive duration; or o Without adequate monitoring; or o Without adequate indications for its use; or o In the presence of adverse consequences which indicate the dose should be reduced or discontinued . During a review of the manufacturer's labeling for Advair Diskus, dated 2/2019, the manufacturer's labeling indicated, ADVAIR DISK US is a combination product containing a corticosteroid and a long-acting bcta2-adrcnergic agonist ([NAME]) . ADVAIR DISKUS should not be used more often than recommended, at higher doses than recommended, or in conjunction with other medicines containing [NAME], as an overdose may result. Clinically significant cardiovascular effects and fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs. Patients using ADVAIR DISKUS should not use another medicine containing a [NAME] (e.g., salmeterol, formoterol fumarate, arformoterol tartrate, indacaterol) for any reason. During a review of the manufacturer's labeling for Serevent Diskus, dated 10/2022, the manufacturer's labeling indicated under Warnings and Precautions, indicated, Do not use in combination with an additional medicine containing a [NAME] because of risk of overdose . SEREVENT DISKUS should not be used more often than recommended, at higher doses than recommended, or in conjunction with other medicines containing [NAME], as an overdose may result. Clinically significant cardiovascular effects and fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs. 47858

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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** 31333 Based on observation and interview, the facility failed to ensure opened boxes of oral inhalation medications with a shortened expiration date once opened, had an open date (the date the medication was first opened) for three of three sampled residents (Resident 30, Resident 53, and Resident 54). The deficient practice of failing to label oral inhalation medications, per the manufacturers' requirements increased the risk that residents with asthma (chronic inflammatory disease of the lungs) or chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) could have received expired or ineffective medications which could result in health complications, difficulty breathing, or hospitalization . Findings: During a review of Resident 30's Admission Record (document containing diagnostic and demographic information), the Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included asthma and COPD. During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 30 had intact cognition (ability to understand and process information). During a review of Resident 53's Admission Record, the Admission Record indicated Resident 53 was admitted to the facility on [DATE]. Resident 53's diagnoses included COPD. During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53 had moderate impaired cognitive skills. During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 54's diagnoses included pulmonary fibrosis (a lung disease that causes scarring in the lungs, making it difficult to breathe), pneumonia (an infection/inflammation in the lungs), and acute respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (a low level of oxygen in the blood), and COPD. During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 had intact cognition. During an observation on [DATE] at 10:14 AM with Licensed Vocational Nurse (LVN) 1, on Nursing Station 1, the MedCart was inspected, and the following oral inhalers used to treat breathing difficulty was observed inside of the MedCart opened without an open date for: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056014	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookfield Healthcare Center	9300 Telegraph Road Downey, CA 90240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident 30, two inhalers, one inhaler of Advair Diskus (a medication that contains both an anti-inflammatory medicine (fluticasone propionate) and a long-acting bronchodilator (salmeterol), used to treat asthma and COPD) 250 micrograms ([mcg] - unit of measure of weight)/ 50 mcg and one inhaler of Serevent (salmeterol) 50 mcg. 2. Resident 53, one inhaler of Arnuity Ellipta (fluticasone furoate, used to prevent and control symptoms of asthma for better breathing) 100 mcg. 3. Resident 54, one inhaler of Advair 250 mcg/50 mcg. During a concurrent observation and interview on [DATE] at 10:14 AM, with LVN 1, LVN 1 stated, the four inhalers (two Advair Diskus inhaler, one Serevent Diskus inhaler, and one Arnuity Ellipta inhaler) observed inside of Nursing Station 1 MedCart were open and did not have an open date. LVN 1 stated there should have been an open date indicated on the medication containers to ensure the inhalers would be good to use for the residents (Resident 30, Resident 53, and Resident 54) and to know when the medications should be discarded. LVN 1 stated if the inhalers were administered after expired, the medications may not be as effective for the residents and could lead to respiratory issues, that included shortness of breath or symptoms of oxygen desaturation (low levels of oxygen in the blood and symptoms include shortness of breath, rapid heart rate, rapid breathing, and confusion) During an interview on [DATE] at 3:24 PM with the Director of Nursing (DON), the DON stated the inhalers with shortened expiration dates, that include Advair Diskus, Serevent Diskus, and Arnuity Ellipta should have an open date. The DON stated expired inhalers may not be effective for the residents (Resident 30, Resident 53, and Resident 54) and residents could experience shortness of breath, respiratory concerns or result in an emergency transfer to the hospital. During a review of the facility's policy and procedures (P&P), titled, Administration Procedures For All Medications, dated ,d+[DATE], the P&P indicated, If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information .Check expiration date on package/container before administering any medication. When opening a multidose container, place the date on the container. During a review of the manufacturer's labeling for Advair Diskus, dated ,d+[DATE], the manufacturer's labeling indicated, Write the date you opened the foil pouch in the first blank line on the label .Write the use by date in the second blank line on the label .That date is 1 (one) month after the date you wrote in the first line. During a review of the manufacturer's labeling for Serevent Diskus, dated ,d+[DATE], the manufacturer's labeling indicated, Safely throw away SEREVENT DISKUS in the trash 6 weeks after you open the foil pouch or when the counter reads 0, whichever comes first. Write the date you open the pouch on the label on the inhaler. During a review of the manufacturer's labeling for Arnuity Ellipta, dated ,d+[DATE], the manufacturer's labeling indicated, Safely throw away ARNUITY ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler. 47858